Engayne Primary School Asthma Medication Form.

Name of Child _____

Name of Parent. _____

Address _____

_____

Contact Number _____ **Mob.** _____

Doctor _____

Name of Medication. _____

Dosage. (How many puffs.) _____

Frequency. (How many times.) _____

Please feel free to add any comments regarding your child's medication, treatment regime or when your child needs their medication.

_____

_____

_____

_____

_____

_____

Your child will be supervised by a First Aider in the administration of their medication.

Signature of Parent. _____

Date. _____

Please complete and return this form to school along with your child's inhaler.