Engayne Primary School Asthma Medication Form.

Name of Child ______________________________

Name of Parent. ______________________________

Address ______________________________

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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.

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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.