West Sussex County Council
Steyning C of E Primary School
Shooting Field STEYNING BN44 3RQ
Tel: (01903) 813420

Website www.steyningprimary.org.uk
e.mail office@steyningprimary.w-sussex.sch.uk

Headteacher Sue Harrison M.A. NPQH

Individual protocol for Mild Asthma

Please complete the questions below, sign this form and return without delay.

CHILD'S NAME ……

D.O.B. ……

Class ……

School use attach photo here

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

1. Does your child need an inhaler in school? Yes / No (delete as appropriate)

2. Please provide information on your child's current treatment. (Include the name, type of inhaler, the dose and how many puffs?)

……

Do they have a spacer?

……

3. What triggers your child's asthma?

……

4. It is advised that pupils have a spare inhaler in school. Spare inhalers may be required in the event that the first inhaler runs out is lost or forgotten. Inhalers must be clearly labelled with your child's name and must be replaced before they reach their expiry date. The school will also keep a salbutamol inhaler for emergency use.

Please delete as appropriate:

- My child carries their own inhaler YES / NO
- My child REQUIRES/DOES NOT REQUIRE a spacer and I have provided this to the school office.
- I am aware I am responsible for supplying the school with an in date inhaler(s)/spacer for school use and will supply this/these as soon as possible. YES / NO

5. Does your child need a blue inhaler before doing exercise/PE? If so, how many puffs?

……

6. Do you give consent for the following treatment to be given to your child as recognised by Asthma Specialists in an emergency? - Yes/No (delete as appropriate)

- Give **6 puffs of the blue inhaler via a spacer**
- Reassess after 5 minutes
- If the child still feels wheezy or appears to be breathless they should have a further **4 puffs of the blue inhaler via a spacer**
- Reassess after 5 minutes
- **If their symptoms are not relieved with 10 puffs of blue inhaler then this should be viewed as a serious attack:**
- **CALL AN AMBULANCE and CALL PARENT**
- **While waiting for an ambulance continue to give 10 puffs of the reliever inhaler every few minutes**

Please sign below to confirm you agree the following:

- I agree to ensure that my child has in-date inhalers and a spacer (if prescribed) in school.
- I give consent for the school to administer my child's inhaler in accordance with the emergency treatment detailed above.
- I agree that the school can administer the school emergency salbutamol inhaler if required.
- I agree that my child's medical information can be shared with school staff responsible for their care.

Signed:……Print name…… Date……
I am the person with parental responsibility

Please remember to inform the school if there are any changes in your child's treatment or condition. Thank you

Parental Update (only to be completed if your child no longer has asthma) My child …….. no longer has asthma and therefore no longer requires an inhaler in school or on school visits.	
Signed *I am the person with parental responsibility*	Date

For office use:

	Provided by parent/school	Location (delete as appropriate)	Expiry date	Date of phone call requesting new inhaler	Date of letter (attach copy)
1st inhaler		With pupil/In classroom			
2nd inhaler Advised		In office/first aid room			
Spacer (if required)					
Record any further follow up with the parent/carer:					

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Individual protocol for Antihistamine as an initial treatment protocol for mild allergic reaction

CHILD'S NAME .....

D.O.B. .....

Class .....

School use attach photo here

Nature of Allergy:

.....

.....

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION - Antihistamine

Name of antihistamine & expiry date .....

- **It is the parents responsibility to ensure the Antihistamine has not expired**

Dosage & Method: **As prescribed on the container.**

- **It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative.....Date.....

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education, and I give my consent to the school to administer antihistamine as part of my child's treatment for anaphylaxis. I confirm I have administered this medication in the past without adverse effect.

Signed:.....Print name:.....Date:.....
I am the person with parental responsibility

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Individual protocol for an Emerade adrenaline auto injector

CHILD'S NAME ……

D.O.B. ……

Class ……

Nature of Allergy:

……

School use attach photo here

……

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION - Emerade

Name on Emerade & expiry date: ……

- **It is the parents responsibility to supply 2 EMERADE auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure …… does not eat any food items unless they have been prepared / approved by parents.**
- **It is the school's responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative……Date……

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education.**
- **I give my consent for the school to administer my child's Emerade or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan**

Signed:……Print name:…… Date:……

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Individual protocol for an Epipen adrenaline auto injector

CHILD'S NAME .....

D.O.B. .....

Class .....

Nature of Allergy:

.....

School use attach photo here

.....

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name
Phone No:
Address:

MEDICATION - EPIPEN

Name on EPIPEN & Expiry date: .....

- **It is the parents responsibility to supply 2 EPIPEN auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure ..... does not eat any food items unless they have been prepared / approved by parents.**
- **It is the school's responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative.....Date.....

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education.**
- **I give my consent for the school to administer my child's Epipen or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan**

Signed:.....Print name:..... Date:.....

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Individual protocol for an Jext pen adrenaline auto injector

CHILD'S NAME .....

D.O.B. .....

Class .....

Nature of Allergy:
.....

School use attach photo here

.....

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION - JEXT

Name on JEXT & expiry date: .....

- **It is the parents responsibility to supply 2 JEXT pen auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure ..... does not eat any food items unless they have been prepared / approved by parents**
- **It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative.....Date.....

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education.**
- **I give my consent for the school to administer my child's Jext pen or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan.**

Signed:.....Print name..... Date.....

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Individual protocol for Antihistamine as an initial treatment for HAY FEVER

CHILD'S NAME .....

D.O.B. .....

Class .....

School Photo NOT REQUIRED

Nature of Allergy:

.....

.....

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable, please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION - Antihistamine

Name of antihistamine & expiry date .....

- **It is the parents responsibility to ensure the Antihistamine has not expired**

Dosage & Method: **As prescribed on the container.**

- **It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative.....Date.....

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education, and I give my consent to the school to administer antihistamine as part of my child's treatment for hay fever. I confirm I have administered this medication in the past without adverse effect.

Signed:.....Print name:.....Date:.....
I am the person with parental responsibility