Form 9

# NEW STUDENT STARTER PACK

## School Asthma Register

To enable us to compile an accurate register of our students' health needs could you please answer the following questions and return the form to school in the envelope provided?

Thank you for your cooperation.

1. Does your child suffer from Asthma? _____
2. What treatment does your child require? _____

   What inhaler _____

   Dosage _____
3. What triggers your child's asthma? _____
4. What is your child's best Peak Flow? _____
5. In case of Emergency _____

   (i) Preferred treatment

   (ii) Contact Number _____
6. Name of G. P. _____ Tel No. _____

**Additional Comments** _____

**Signature** _____ **Date** _____

**N. B.** If your child has an asthma attack which does not respond to his / her treatment the Emergency Services will be contacted.