

Dear \_\_\_\_\_  
(Educator's name/s)

My child \_\_\_\_\_ suffers from \_\_\_\_\_

His/ Her condition is usually triggered by:

\_\_\_\_\_

\_\_\_\_\_

Specific things to be avoided include:

\_\_\_\_\_

The symptoms he/she usually exhibits with this condition are:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This first sign is usually:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Routine Medications:**

**Important Note:**

Medications must be in its original container with the original label, the child's name of whom the medication is to be given, dosage, frequency and before the expiry or use date.

Please assist my child to take the following medication every day.

Medication	Dose	Delivery Device

Special instructions:

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How is the medication administered?

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**Before Exercise:**

Before exercise, please administer:

Medication \_\_\_\_\_

Dose \_\_\_\_\_

Device \_\_\_\_\_

***If symptoms develop despite this, please stop his/her activity and sit or lie down.***

Please give:

Medication \_\_\_\_\_

Dose \_\_\_\_\_

Device \_\_\_\_\_

Special instructions:

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Managing an acute attack:

If my child has an acute attack of the condition, please give:

Medication a) \_\_\_\_\_ b) \_\_\_\_\_

Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Device \_\_\_\_\_

Special Instructions:

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If there is no Improvement, please contact me by telephone on: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**In an Emergency**

I am aware that in an emergency an ambulance may be called.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Parent/ Guardian)

Medicare Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**Doctor's Details**

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address:  
 \_\_\_\_\_

**Permission to self-Administer**

I give permission for my school aged child to self-administer their own asthma medication.

(Please circle) Yes/ No Parent Signature: \_\_\_\_\_

***Pebbles Family Day Care requires a health care plan; children are not permitted to attend care without their medication as prescribed on the Health Care Plan.***

**Parent/Guardian Name:** \_\_\_\_\_ **Sign:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Educator Name:** \_\_\_\_\_ **Sign:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Office Use Only:**

Is a Health Care Plan required? Yes/ No

Coordinator Name: .....

Coordinator Signature: ..... Date: ...../...../.....