INHALER

St Teresa's Catholic Academy

Headteacher: Mrs N Peters

CONSENT TO ADMINISTRATION OF AN INHALER

Pupil's Name:	
Date of Birth:	
Home Address:	

Parent(s)/Carer(s) Name:	
Emergency Contact Telephone No:	Home: Mobile:
Name of GP:	
Medical Practice:	
Medical Practice Telephone Number:	

Prescribed Emergency Treatment & Dosage: (How many puffs & how often)	

Parents' agreement to the administration of prescribed treatment by trained volunteer staff.

Signed: ..... Date: .....

Ofsted Outstanding 2009|2010

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