Asthma Management Procedure Policy

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Version Control

Ver.	Date	Comment
1	November 2024	Initial Trust model to replace various school policies
2	January 2026	Minor update to include vaping alongside smoking and inclusion of Asthma UK pre-school asthma guidelines for schools with EYFS pupils

This policy will be subject to ongoing review and may be amended prior to the scheduled date of the next review in order to reflect changes in legislation, statutory guidance, or best practice (where appropriate).

Contents

1. Introduction

According to the charity Asthma UK there are around 5.4 million people nationally who are currently receiving treatment for asthma. This is around one in every 12 adults and one in every 11 children so, on average, 2 or 3 children in every classroom have asthma. Research has shown that two thirds of asthma deaths in the UK are preventable.

Asthma is a long-term condition that affects the airways (the tubes that carry air into and out of the lungs) and usually causes symptoms such as coughing, wheezing, and breathlessness.

If someone with asthma comes into contact with one of their asthma triggers, it can make their symptoms worse and even bring on an asthma attack.

Someone with asthma has 'sensitive' airways that are inflamed and ready to react when they come into contact with something they do not like. Coming into contact with one of their asthma triggers causes a person's airways to react in three ways:

- The muscles around the walls of the airways tighten so that the airways become narrower.
- The lining of the airways becomes inflamed and starts to swell.
- Sticky mucus or phlegm sometimes builds up, which can narrow the airways even more.

These reactions in the airways make it difficult to breathe and lead to asthma symptoms, such as chest tightness, wheezing, or coughing. It can also lead to an asthma attack.

Having frequent asthma attacks can also make asthma worse over time because they can cause scarring in the airways (sometimes called 'airway remodelling') which makes them narrower. Someone with scarred and narrow airways is more likely to have worse symptoms more often.

Most people with asthma who get the right treatment (and take it correctly) and who understand how to manage their symptoms and control their exposure or reaction to triggers are able to get on with what they want to do in life.

2. Rationale

Eden Pinkwell Satellites recognises the important part that nurseries, schools, and colleges play in helping children and young people with asthma manage their condition well to achieve good health, active learning, and personal independence.

We recognise that some pupils may need time off school or suffer disturbed sleep due to their asthma symptoms which can leave them feeling ill, tired, and irritable, and struggling to concentrate or catch up at school.

These procedures centre on the safeguarding of pupils diagnosed with asthma.

This school welcomes all pupils, including those who have asthma, and encourages them to achieve their full potential in all aspects of school life by

providing a positive educational environment, procedures to control the risks to people with asthma and prevent and manage attacks, and well-trained staff to implement them.

So that pupils diagnosed with asthma can be fully integrated into school life, we will:

- ensure that those with asthma can and do participate fully in all aspects of school life, including PE, design technology, science, educational visits, and other extended school activities by understanding a pupil's severity of asthma and their triggers, assessing the risks and implementing control measures to try to reduce them, and having sound emergency management procedures.
- have arrangements in place to ensure that those with asthma can get immediate access to their reliever inhaler at all times.
- keep a record of all pupils diagnosed with asthma and the medicines they take (asthma register) and have an Health Care Plan (HCP) in place for pupils who need one.
- ensure that the whole school environment, including the physical, social, sporting, and educational environment, is favourable to those with asthma.
- ensure there is an area of school that allows for adequate privacy and supervision where necessary for pupils who are uncomfortable using an inhaler in front of others.
- ensure that all staff and other adults working in the school and who come into contact with pupils with asthma know what asthma is, what asthma symptom triggers are relevant to their work, how to best control the triggers and reactions, how to recognise an asthma attack, and what to do in the event that a pupil has one.
- ensure that all pupils understand asthma so that they can support their peers; and so those with asthma can avoid the stigma sometimes associated with the condition (this might include how to recognise an asthma attack and what to do in the event that another pupil has one when pupils are old or mature enough and may be without close adult supervision).
- take steps to ensure that pupils with asthma are not being bullied by others and apply our anti-bullying procedures to prevent this.
- work in partnership with all interested parties including the governing body, all school staff and other adults, the school or community asthma nurse, parents and carers, other employers of adults working in the school (e.g., cleaning and catering staff), the local health protection team, and pupils to ensure these procedures are, implemented and maintained successfully.

3. Managing pupils' asthma medicines

Pupils with asthma need immediate access to their reliever medicine and are encouraged to carry their reliever inhaler as soon as their parent or carer, GP or asthma nurse, and class teacher agree they are mature enough. The reliever inhalers of children who are not capable of carrying it safely themselves are kept in their classroom.

It is explained to all staff as part of their induction that any child who appears to need or has asked for their reliever inhaler should be given it immediately and what procedure they must follow.

We ask all parents and carers to ensure that they provide school with a spare reliever inhaler (and spacer device if required) which they have clearly labelled with their child's name. An appropriate member of staff will hold this device separately in case the pupil's own inhaler runs out, or is damaged, lost, or forgotten.

It is the responsibility of parents and carers to ensure that medicines provided by them for their child to use at school have a reasonable length of time left before their expiry date considering how long we will need to keep it. For example, a preventer inhaler to be used once a day after breakfast and due to expire in 2 weeks will be acceptable when school only needs to hold it for a 2-night residential starting that day. A reliever inhaler which may be required infrequently but could be needed at any time should have no less than 2 months left before it expires on the day it is received so that the expiry will be flagged in good time to request a replacement by the regular medicines check we carry out.

If it comes to the attention of staff through their normal duties or regular checks that a medicine has expired or will expire soon, we will inform a parent or carer and ask for a replacement.

If a pupil appears to be using their reliever inhaler more often than expected according to the needs outlined in their HCP, we will inform their parents/carers. We might need to review the child's plan with them, or the child might need to see their GP or a community asthma nurse for an asthma review after which we might also need to review their child's plan with them.

It will be agreed between school and home and recorded on the HCP how parents or carers would like to be informed about their child's use of their asthma medicines. Notifications can be in person face-to-face at the end of the school day or by paper slip (see appendix) telephone call, SMS, email, school diary etc.

School staff are not required to administer asthma medicines to pupils (except in an emergency), however many staff at this school are trained and willing to either do this, or to supervise or provide other support to a pupil whilst they self-administer.

School staff who agree to administer medicines are insured by the local authority/governing body to do so when they are acting in accordance with our policies and their training given the circumstances they faced at the time.

4. Procedure for inhaler administration

The procedure for obtaining and using a pupil's asthma reliever inhaler and the school owned emergency salbutamol inhaler are the same but with slight variations affecting certain staff e.g., where the easily accessible but secure place pupils' own inhalers are kept if they cannot carry them, the nearest spare to their work area etc.

The school-owned emergency salbutamol inhaler can only be used by children, for whom written parental consent to use it has been given and who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

A pupil who has been prescribed an inhaler for their asthma which contains an alternative reliever medicine to salbutamol (such as terbutaline), should still use the salbutamol inhaler if their own inhaler is not accessible and consent is held – it will still help to relieve their asthma symptoms and could save their life.

All children with a diagnosis of asthma should have a written Asthma Care Plan or School Asthma Card and can complete an Asthma Care Plan or the School asthma card – Asthma + Lung UK (http://www.asthmaandlung.org.uk), although a generic Individual Health Care Plan (IHCP) is not unsuitable.

Salbutamol inhalers are intended for use where a child has asthma. The symptoms of other serious conditions and illnesses, including allergic reaction, hyperventilation, and choking from an inhaled foreign body can be mistaken for those of asthma, and **the use of the emergency inhaler in such cases could lead to a delay in the child getting the treatment they need.**

In an emergency which resembles symptoms of asthma in a pupil who has not been prescribed a reliever inhaler and who does not have a medical plan that indicates school should administer the school emergency salbutamol either, the rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations the member of staff administering it, in an emergency and acting under medical instruction, does not need to have had any specialist training.

Staff will supervise or otherwise support a pupil who is able to self-administer their own or the school emergency inhaler, or they will administer it for pupils who are unable to self-administer it in accordance with their training and the posters 'How to recognise an asthma attack'; and 'What to do in the event of an asthma attack'.

Staff will be aware of and prepared to manage the well-known, normally mild, and temporary side effects of inhaling salbutamol which are not likely to cause serious harm e.g., the child feeling a bit shaky or trembling and their heart beating faster.

5. Summary of action staff should take in response to a suspected asthma attack

1. Establish that the pupil in difficulty is experiencing an asthma attack as far as possible and try to keep them calm.

2. Establish the pupil's identity and the correct action to take i.e., whether appendices C and D should be followed or the pupil's individual S/MART Plan i.e., their Maintenance and Reliever Therapy plan (using only one combination preventer/reliever inhaler – app enabled smart inhalers are not available in the UK yet).
3. Obtain the child's inhaler, the child's spare inhaler, and/or the school emergency inhaler and spacer if required.
4. Check the medicine to be administered is correct, not expired, and will be given at the right dose in the right way i.e., whether a spacer is used or there is a S/MART Plan.
5. Administer or support self-administration of the reliever inhaler in accordance with the posters/advice or the pupil's S/MART Plan and/or the pupil's ACP/IHCP and call for an ambulance if necessary.
6. Record the administration.
7. Inform parents or carers as agreed or as soon as possible if an ambulance has been called.

6. Managing school supplies of salbutamol

The Human Medicines (Amendment) (No.2) Regulations 2014 allows (but does not require) schools to keep a salbutamol asthma reliever inhaler for use in an emergency.

Trustees have agreed to purchase and have school manage at least **2** reliever(s) inhalers and spacers in case of an asthma emergency occurring both on and off at the same time where a child's own inhaler or spare is not available or safe to use. It could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life. **This decision does not in any way release parents or carers from their absolute duty to ensure that their child attends school with a fully functional inhaler containing sufficient medicine for their needs.**

7. Obtaining salbutamol

This school will buy salbutamol, inhalers, and suitable spacer equipment (as advised by a person no less qualified than a pharmacist) from a pharmaceutical supplier in writing confirming the following:

- the name of the school.
- the purpose for which the product is required; and
- the total quantity required.

8. The emergency asthma kit

Each emergency asthma kit will contain:

- 2 salbutamol metered dose inhalers (MDI).
- At least two single-use plastic or disposable spacers compatible with the inhaler (see https://bit.ly/3nATvmj for disposable spacers compatible with Ventolin and Salamol inhalers).

- Manufacturer's information and instructions on using the inhaler and spacer/ plastic chamber.
- Instructions on how to administer the inhaler using a spacer/plastic chamber e.g., https://www.rightbreathe.com/ or How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk) or the inhaler manufacturer's videos.
- Advice that disposable salbutamol inhalers and spacers are for use by one person only because of the risk of Covid. Instructions on storing and disposing of single use inhalers/spacers and/or instructions on cleaning and storing inhalers and spacers that are not disposable and are allocated and limited to the use of one person.
- The issuing pharmacist's contact information.
- A checklist of inhalers, identified by batch number and expiry date, with monthly checks recorded.
- A note of the arrangements for replacing the inhaler and spacers.
- A list of children permitted to use the emergency inhaler as detailed in their IHCP or other written parental consent (asthma register).
- A record of administration (i.e., when the inhaler has been used).
- Pen.
- Asthma champion's name and contact details.

9. Storage and care of inhalers

It is the responsibility of Health care plan manager and Health and safety co-ordinator to maintain the school emergency asthma kit ensuring that:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available.
- replacement inhalers are obtained when expiry dates approach.
- replacement spacers are available following use.
- the plastic inhaler housing (which holds the canister) has been cleaned, dried, and returned to storage following use, or that replacements are available if necessary.

Inhalers and spacers are kept in the Satellite Office and Primary Kitchenette which is a safe and suitably central location in school, known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. They will not be locked away. School inhalers and spacers will be kept separate from any child's own prescribed inhaler which is stored in a nearby location and the emergency inhaler will be clearly labelled to avoid confusion with a child's own device.

Storage will always be in line with manufacturer's guidelines, usually below 30°C and protected from direct sunlight and extremes of temperature. Spacers will not

be stored in plastic bags to avoid them developing a static charge that causes the asthma medicine stick to the spacer rather than being delivered into the lungs.

An inhaler should be tested before use e.g., held away from the face while spraying one or more puffs as necessary. As it can become blocked again when not used over a period of time, testing will be carried out before each use and monthly as part of the working order checks.

To avoid possible risk of cross-infection and because it goes directly in the mouth and can only be cleaned with gentle detergents, the plastic spacer cannot be reused by a different person and could be given to the child who used it to take home/keep labelled with their name in school for future personal use. The inhaler itself however can usually be reused, provided it is cleaned after use. The canister of salbutamol should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, the cap replaced, and the inhaler returned to the designated storage place. If there is any risk of contamination with blood i.e., if the inhaler has been used without a spacer, it should not be re-used but disposed of.

10. Disposal

This school is registered online at www.gov.uk/waste-carrier-or-broker-registration as a waste carrier so that we can legally dispose of spent, expired, or faulty inhalers and salbutamol canisters or return them to be recycled by the manufacturer and will follow the manufacturer's or our pharmaceutical suppliers' guidelines on disposal. We return all to the pharmacist who supplies for disposal.

11. Staff training on and use of inhalers

The individual responsible for overseeing the protocol for use of the school emergency inhaler, monitoring its implementation, and for maintaining the asthma register is the healthcare plan manager.

All staff are trained to recognise symptoms of an asthma attack, how to distinguish symptoms from choking or other conditions with similar symptoms, and how to respond to an attack appropriately.

Designated staff have a specific responsibility for helping to administer the school emergency inhaler, i.e., they have volunteered to help a child use the school emergency inhaler, are trained to do so, and are identified in these procedures as people to whom all staff can turn to for support in an asthma emergency.

All staff are also made aware of:

- the school policy for supporting pupils at school with their medical conditions, and their role.
- our asthma procedures, and their role in them.
- how to check if a child is on the asthma register or has an ACP/IHCP.
- how to access and use the school's emergency inhaler.

- who the designated members of staff are and how to summon their help.

Pupils are involved in age and developmentally appropriate ways in our emergency asthma procedures e.g., fetching help or equipment, to increase community asthma awareness, build peer-to-peer resilience, promote leadership skills, and reduce stigma or bullying.

Designated staff are trained in everything that all staff are trained in listed above and:

- responding appropriately to a request for help from another member of staff.
- recognising when emergency action is necessary.
- administering salbutamol inhalers through a spacer.
- making appropriate records of asthma attacks; and
- ensuring parents are informed (see letter of notification or the HCP).

We ask children with inhalers to demonstrate to their teachers how they use it, with parental support, if necessary, to understand their technique, to compare it with their asthma care plan and training staff have received.

We use Asthma UK resources, free and accredited online training from the George Coller Memorial Fund, manufacturer's user training materials, and specific training or advice offered by the school or community asthma nurse or another suitably qualified professional to inform our practice when managing pupils who have asthma.

12. Record keeping

At the beginning of each school year or when a child joins our school, parents/carers are asked if their child has any medical conditions, including asthma, on their enrolment form.

All parent/carers of pupils with asthma are asked to complete an Asthma UK School Asthma Card sometimes known as an Asthma Care Plan or an Health Care Plan with advice from their GP or asthma nurse where needed to help us manage their child's asthma symptoms during school activities.

The information will be used to update the school asthma register, which is made available to all school staff and other adults working in the school to ensure reliever medicines are administered appropriately.

We review all asthma plans at least annually, asking parents and carers to update their existing plan or exchange it for a new one and we remind them to tell us as soon as possible if their child's condition or medical needs changes.

Use of a pupil's own reliever inhaler is recorded and notified if necessary and as agreed with parents/carers.

The use of the school emergency inhaler is recorded every time in the **record of** **"**emergency inhaler administer to pupils book" and reported to parents/carers via telephone call and in writing.

13. Exercise and activity - PE and games

Taking part in sports, games and physical activities is an essential part of school life for all pupils but can be a trigger for pupils with asthma.

To maximise participation by and minimise the risks to pupils with asthma we:

- Take reasonable steps to make the activities we offer accessible so that they can participate alongside their peers e.g., moving an outdoor activity indoors at times of very high pollen counts, if necessary, kit checks that include inhalers.
- Ensure all staff and other activity leaders are aware which of the pupils they work with have asthma, how to recognise an asthma attack, and what to do, and have access to the emergency asthma kit and asthma register e.g., in the school emergency asthma kit they might need to use.
- Require all activity leaders to remember to include emotions and pollen in their dynamic risk assessments and take steps to control asthma triggers where possible including regularly reminding pupils at risk how to reduce their exercise-related triggers or reduce their response to triggers e.g., using their reliever inhaler just before warming up for exercise.
- Require all activity leaders to encourage pupils experiencing worsening asthma symptoms to stop, take their reliever inhaler and to sit out quietly until their symptoms have gone before starting the activity again. Anyone experiencing asthma symptoms must not be left alone until they feel better and are continuing with normal activities.
- Have a simple procedure for ensuring pupils' own inhalers are easily available to them during activities when they are not competent to or cannot physically carry them which is clearly communicated with signage if necessary. Procedures vary slightly depending on the pupils and locations, but they all involve the principle of staff gathering clearly labelled personal inhalers, storing them in a hygienic manner which is immediately accessible to pupils throughout activities, carrying or having access to a pupil's own spare inhaler if they have one, and returning them.
- Have clear learning objectives for and plans for the inclusion of pupils with asthma who are too unwell to participate in physical activities e.g., referee, coaching, or other lower risk role.
- Take steps to reassure parents, carers, and pupils that we understand their asthma and can help them manage it and be active.

14. Out of hours

Extra-curricular activities and out-of-school clubs operated by this school are open to all pupils equally and those with asthma are encouraged to participate in everything we offer alongside their peers.

To enable pupils with asthma to participate as safely as possible, we ensure that all teaching, teaching support staff, sports coaches, and other activity leaders who

run school activities outside of normal school hours are aware of our asthma procedures and the pupils they need to be applied for.

Adults leading physical activities are provided with information about minimising asthma triggers and how to encourage pupils to use the advice.

15. School environment

This school does all that we reasonably can to ensure the school environment is as favourable to pupils with asthma as it is to their peers who do not have the condition.

We also have a duty of care for the health, safety, and wellbeing of pupils and must identify the seriousness of the risks to their health from exposure to their known triggers of asthma and take action to eliminate or manage the risks.

Areas of the curriculum we pay particular attention to which may expose pupils to humidity, extremes of temperature, fumes, smoke, dust, and other aerosol pollutants include science, design technology, food technology, art, religious studies, drama, and PE.

We do not own or keep animals that are known asthma triggers and where it is unavoidable that contact with an animal trigger can become e.g., in the presence of disability service animals or on educational visits off-site, we carefully manage situations that may cause an asthma attack.

This school has a strict 'no smoking / vaping' policy in force throughout the site, both indoors and outdoors, and steps are taken to ensure that staff and other adults leading or supervising off-site visits also adhere to this policy.

This school is kept well-ventilated to control humidity and temperature, and to prevent dust accumulation, damp, and mould through open doors and windows in line with our security and our fire risk assessment.

We actively look for damp and mould problems through normal premises condition monitoring and take action to prevent and deal with incidents as a high priority.

Local Exhaust Ventilation (LEV) systems are regularly maintained, and checks carried out to ensure that equipment is effectively situated and working well.

When we have pupils or staff with severe asthma triggered by dust, we will ensure classrooms and any other areas necessary are regularly wet dusted to reduce dust and dust mites.

When contractors are on site, regular discussions take place with them to ensure that their work will not increase risks to pupils or staff with asthma in an unmanageable way e.g., create fumes, smoke, dust etc.

Where possible, grassed areas are not mowed during school hours, and we avoid keeping pollinating plants inside school buildings.

Rooms where pupils change their clothing are well ventilated and pupils are encouraged to use unscented and non-aerosols deodorants or other permitted products.

16. Off-site and residential visits

All procedures to be followed on-site to manage asthma, including pupils carrying their own reliever inhaler if they can and staff support for the administration of other asthma medicines or treatments like preventer inhalers, oral steroids, or nebulisers not usually administered during normal school hours, have been adapted to be carried out off-site.

Visit leaders are expected to check the medical needs of pupils in good time to ensure equality of access to the curriculum and to be adequately prepared for their educational visit e.g.

- to understand which pupils, have asthma.
- the severity of their symptoms.
- relevant triggers to be avoided or reduced.
- their treatment or care plan and the role of staff in it.
- and the pupil's competence in carrying and administering their own medicines.

Parental consent to attend a residential visit may need to include additions to the asthma plan because a preventer medicine or other treatment school does not normally manage is required.

All medicines provided for educational visits must be provided to school clearly labelled with the pupil's name by parents or carers.

17. When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their asthma is disturbing their sleep at night, the class teacher, supported by their line manager will initially talk to the parents/carers to develop a plan to support better management of their asthma and/or to prevent their child from falling behind. If appropriate, the teacher will then talk to the school nurse and special education needs coordinator about the pupil's needs.

We recognise that it is possible for pupils with asthma to have special education needs due to their asthma.

18. Bullying

Whilst bullying can happen to any pupil, this school recognises that those who feel or seem different to others can be particularly vulnerable. Our Anti-bullying procedures which are part of the Whole School Behaviour Policy will be used and enforced in any situation where a pupil is being bullied or intimidated due to their medical condition.

19. Disclaimer

While every effort will be made to ensure that the appropriate medical attention is sought at the earliest opportunity in the event of a pupil experiencing an asthma emergency, this school cannot accept responsibility for adverse events when

parents/carers have failed to provide the working reliever inhaler their child needs to manage their asthma symptoms.

20. Access to and review of procedures

The Asthma Procedures will be accessible to all staff and other adults working in the school and the community on request. A printed copy is available from the school office.

These procedures will be reviewed on a two-yearly cycle.

Appendix 1: Template letter to parents of pupils diagnosed with asthma

Date:

Dear Parent\Carer

School Asthma Care Plan

We take our responsibility for supporting pupils at school who have been diagnosed with asthma very seriously and are committed to providing a high quality and safe educational experience.

This school has clear asthma procedures in place to enable all staff members and other adults who work with your child/ren to help them manage their condition well.

To ensure your child receives the best possible care at all times, please help us by:

- Completing and signing the School Asthma Card enclosed (if you are not sure about treatment details, please take the form to your doctor, asthma nurse, or dispensing pharmacist for help)
- Telling school immediately of any change in treatment (when appropriate)
- Sending your child/ren who **can** responsibly carry their own reliever (blue) inhaler to school every day with it clearly labelled with their name, in-date and in working condition (with their spacer if this is the usual method of delivery) **and** provide a spare to be kept in school at all times in case theirs fails.
- Providing us with **two** reliever (blue) inhalers during term time for each child who **cannot** responsibly carry their own in school. School will then have a spare in case something is wrong with the first.
- Giving us your consent to administer the school-owned emergency salbutamol inhaler if necessary.
- Bringing in a new spacer to replace ours if your child has used the school emergency spacer and we must keep it in school for their personal use only (your GP can prescribe one).

If your child uses a different asthma symptom reliever medicine from salbutamol e.g., terbutaline, they will still benefit from using the school salbutamol inhaler if their own is not available or working and it could save their life.

Things that can worsen your child/ren's asthma symptoms include exposure to lots of people and the common illnesses they have, getting out of good routines or habits using preventers and relievers over holiday periods, cold weather, hay fever, and stress or anxiety.

You can help your child with all of these things by encouraging good personal hygiene, keeping up with medicine routines, being prepared for the day ahead at

school, and encouraging your child to share their asthma concerns with you and with us.

Please complete the enclosed card even if your child has no symptoms at present and only has a history of asthma. We still need this information. If you prefer to complete, save, and send or print for us a digital pdf version of this form, please use this link to the charity Asthma + Lung UK who developed it School asthma card – Asthma + Lung UK (asthmaandlung.org.uk).

If you have any questions or want to see a copy of our asthma procedures, please ask the school office. Thank you for your co-operation in this important matter.

Yours sincerely

Headteacher

Appendix 2: Asthma UK Asthma Care Plan

School Asthma Card

This card is for your child's school. Review it at least once a year and remember to update or exchange it for a new one if your child's treatment changes during the year. Medicines and spacers should be clearly labelled with your child's name and kept in agreement with the school's policy and procedures on managing asthma.

<table>
<tr><td>Child's name:</td><td colspan="2"></td><td>Date of birth:</td><td></td></tr>
<tr><td>Child's address:</td><td colspan="4"></td></tr>
<tr><td>Parent/carer name:</td><td colspan="2"></td><td>Home tel. no.:</td><td></td></tr>
<tr><td>Email address:</td><td colspan="2"></td><td>Mobile tel. no.:</td><td></td></tr>
<tr><td>Doctor/nurse's name:</td><td colspan="2"></td><td>Doctor/nurse tel. no.:</td><td></td></tr>
<tr><td colspan="3">Reliever treatment when needed: For shortness of breath, sudden tightness in the chest, wheezing, or coughing, help or allow my child to take the medicines below. After treatment and as soon as they feel better, they can return to normal activities.</td><td colspan="2">Signs that my child is having an asthma attack:</td></tr>
<tr><td>Medicine</td><td>Parent signature</td><td></td><td colspan="2" rowspan="2">Triggers that can make my child's asthma worse include:
Pollen £ Stress £ Other (please list):
Exercise £ Weather £
Colds/flu £ Air pollution £</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3" rowspan="2">If the school holds a central reliever inhaler and spacer for use in emergencies, I give permission for my child to use this.</td><td colspan="2">My child may need to take other asthma medicines (listed below) while in the school's care: YES - - - £ NO - - - £</td></tr>
<tr><td>Medicine</td><td>How much to take and when</td></tr>
<tr><td>Parent signature</td><td>Date</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td></td><td></td></tr>
</table>

I prefer to be notified about an asthma incident using:

Paper slip £ SMS £ Email £
App £
Telephone call £ Other: _____

My child tells me when they need medicine YES £ NO £

My child needs help taking their medicine YES £ NO £

My child should always use a spacer YES £ NO £

Expiry dates of medicines

Medicine	Expiry	Date checked	Parent signature

If my child is about to exercise or will encounter an unavoidable trigger they should (please describe the treatment plan)**:**

To be completed by the GP practice
Dates this card has been checked

Date	Name	Job title	Signature/Stamp

Parent Carer's signature	Date

Actions to take if a child is having an asthma attack

1. Help them to sit up – don't let them lie down. Try to keep them calm.
2. Help them take one puff of their reliever inhaler (with their spacer, if they have it) every 30 to 60 seconds, up to a total of 10 puffs.
3. If they don't have their reliever inhaler, or it's not helping, or if you are worried at any time, call 999 for an ambulance.
4. If the ambulance has not arrived after 10 minutes and their symptoms are not improving, repeat step 2.
5. If their symptoms are no better after repeating step 2, and the ambulance has still not arrived, contact 999 again immediately.

Appendix 3: How to recognise and what to do in the event an asthma attack posters

How to recognise an asthma attack

Signs that someone may be having an asthma attack include:

- Symptoms that are getting worse e.g. coughing, breathlessness, wheezing, or having a tight chest
- The reliever inhaler is not helping relieve symptoms or is needed more than every four hours
- Being too breathless to speak, eat, walk, or sleep
- The person's breathing is getting faster, and they feel like they cannot catch their breath
- Their peak flow score is lower than normal
- They complain of a tummy or chest ache (more commonly a tummy ache in younger children)

Symptoms will not necessarily occur suddenly. They often come on slowly over a few hours or days.

DIAL 999 FOR AN AMBULANCE IMMEDIATELY IF:

- There is no working reliever inhaler available
- The child feels worse despite using a reliever inhaler
- The child does not improve after taking 10 puffs of their reliever inhaler
- The child:
    - Appears drowsy, confused, exhausted, or dizzy
    - Has blue tinged lips, nails, tongue, gums, skin, or ears
    - Has collapsed

Give paramedics the child's medicines.

What to do in the event of an asthma attack

Do not follow this procedure if the child having the suspected asthma attack is on a MART treatment plan. These are kept in class medical boxes.

- Keep calm and reassure the child
- Encourage the child to sit up straight
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take **one** puff of salbutamol via the spacer
- If there is no immediate improvement, continue to give **one** puff at a time **every 30-60 seconds**, up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until they feel better and can return to school activities
- If the child does not feel better or you are worried at **ANYTIME** before you have reached 10 puffs, **CALL 999 FOR AN AMBULANCE**. Give attending paramedics the child's medicines.
- If an ambulance does not arrive **within 15 minutes** give another 10 puffs in the same way

Inform parents or carers as agreed (no matter how minor) or as soon as possible (if serious).

Appendix 4: Notification of asthma inhaler use

Eden Pinkwell Satellites

Eden Pinkwell Satellites Emergency Salbutamol Use Note

Name of child:		**Date of incident:**	
Child's class/group:		**Time of incident:**	

Dear Parent or Carer,

Today your child has had problems with their breathing. This happened when:

☐ They used their own asthma inhaler *without / with supervision. They took _ _ _ puffs.

☐ A member of staff helped them to use their own asthma inhaler. They took _ _ _ puffs.

☐ They did not have their own asthma inhaler with them, so a member of staff *supervised / helped them to use the emergency spacer and asthma inhaler containing salbutamol. They had _ _ _ puffs.

☐ Their own asthma inhaler *was empty / not working, so a member of staff *supervised / helped them to use the emergency spacer and asthma inhaler containing salbutamol. They had _ _ _ puffs.

Although they soon felt better, we strongly advise that you take your child to see their own doctor as soon as possible.

Please check your child's *inhaler / spacer and ensure we have a spare in school.

If your child used the school emergency spacer, it will be kept in school for their personal use only so please send in a replacement, as agreed, as soon as possible (your GP can prescribe this).

Thank you.

Head Teacher/Class Teacher:	

Appendix 5: Emergency inhaler use: record card

Name of school/satellite						
Date	**Name of child**	**Time**	**Where & when**	**Dose(s) given**	**Staff signature**	**Print name**
1/9/24	*Anne Other*	*14:30*	*Insect sting, PE field*	*1 x Epipen 0.3mg*	*J Smith*	*John Smith*

Appendix 6: Asthma UK pre-school asthma guidelines for schools with EYFS pupils

Preschool wheeze and suspected asthma in children aged under 5 | Asthma + Lung UK

Pre-school wheeze and suspected asthma in children aged under 5

The information in this section will help you to understand the differences between preschool wheeze and suspected asthma in children aged under 5, and how to manage their care.

This is not a substitute for completing appropriate education and training such as a paediatric respiratory assessment module or accredited asthma course. For advice and support on choosing the right course for you, please see our training and development page.

For children aged 5-11 years of age, please see our information on managing asthma in children aged 5-11

Key resources:

- A joint asthma guideline was produced in November 2024 by NICE, BTS and SIGN.
- You can also refer to the NICE Clinical Knowledge Summary for more information, and
- PCRS's First Steps guide.

Wheezing in the child under 5 years old:

- Wheezing in the under 5 age group is often referred to as 'pre-school wheeze' and is not the same as asthma.
- Preschool wheeze is common and affects approximately 30–40% of children under six years old.
- In most cases, preschool wheezing resolves as children grow older—about 60% outgrow it by the age of 6, and 80% by the age of 10.
- Only one in three children with preschool wheeze progress to an asthma diagnosis by their 6th birthday.
- It's important to assess children carefully to avoid misdiagnosis of asthma and under or over treating them.

Preschool wheeze: causes and contributing factors

Viral Infections

Respiratory viruses like rhinovirus, respiratory syncytial virus (RSV), and adenovirus are the leading cause of wheeze in preschool children. These viruses can trigger viral-induced wheeze, especially in children under three.

Airway size

Young children have small airways that are more prone to narrowing when inflamed or congested. As the airways grow, many children outgrow their wheeze.

Atopy and allergic sensitisation

Children with a family history of allergies, eczema, or asthma are more likely to develop wheeze.

Sensitisation to indoor and outdoor allergens (such as house dust mites, pollen, pollution, mould, pets) can contribute to airway inflammation and wheeze.

Smoking

Exposure to tobacco smoke, both during pregnancy and after birth, increases the risk of wheezing.

Prematurity and low birth weight

Babies born prematurely or with low birth weight may have underdeveloped lungs, making them more prone to wheezing.

Gastro-oesophageal reflux

Reflux can lead to airway irritation, causing wheeze in some children.

Other conditions

Rarely, other conditions such as airway malformations, bronchiectasis, or bronchiolitis obliterans can cause wheeze.

Inhaled foreign bodies can occasionally mimic wheeze.

When to suspect asthma

Differentiating preschool wheeze from suspected asthma in children under 5 is often challenging. Making a diagnosis of asthma is hard in this age group because it is difficult to for them to do the tests and there are no good reference standards .

Therefore, children aged under 5 will usually be coded as ‘suspected asthma’ until they are old enough to perform diagnostic testing, which is generally around 6 years of age.

Assessing the child with suspected asthma

You firstly need to find out if it is more likely that the child has preschool wheeze or suspected asthma.

Use the guide below to help you to ask the right questions. You can send our How to Spot Asthma in your Child video to parents and carers before their appointment, so they can start thinking about their child’s symptoms. It’s helpful if they can record their child’s symptoms on their phone, too.

Question to ask	Why this question matters
Is your child's chest or breathing ever noisy? What does it sound like?	Avoid using the term 'wheeze' as this will be different for each person. Instead, ask them to describe how their child's chest sounds or record them on their phone if they can.
When does your child have a noisy chest? Does it only happen when they have a cold? Does this happen even when your child is well and able to play as normal?	Wheeze only during colds is often viral wheeze, which is usually transient. Asthma is more likely if wheeze occurs between colds or without infection , this is called an 'interval symptom'. Exercise-induced wheeze is a classic asthma feature, reflecting airway hyperresponsiveness. Viral wheeze is less likely to occur with exercise.
Does your child have symptoms like a noisy chest, cough, or breathlessness at night or in the early morning?	Asthma symptoms often worsen at night due to airway inflammation. Night-time or early morning symptoms are a strong indicator of asthma.
Does your child have eczema, hay fever, or other allergies?	Atopy (eczema, hay fever, or allergies) is strongly linked to asthma development. Preschool wheeze with atopy increases the risk of asthma.
Is there a family history of asthma, eczema, or allergies (including food allergies)?	Family history of atopy (asthma, eczema, or allergic rhinitis) increases the likelihood that the child's wheeze is asthma-related.
Have you noticed any specific triggers for your child's chest symptoms (e.g., pollen, pets, dust, smoke, exercise, cold air)?	Symptoms in response to triggers make an asthma diagnosis more likely. Viral wheeze is less likely to have specific non-viral triggers.
Was your child born prematurely?	Premature birth, defined as delivery before 37 weeks of gestation, has been associated with an increased risk of developing asthma in both childhood and adulthood.

The visual aid below will also help you to decide if preschool wheeze or suspected asthma is the most likely diagnosis.

YES	Does the child have interval symptoms when they do not have viral infections?	NO
YES	Are the exacerbations severe and/or frequent?	NO
YES	Are any of the following markers present? • Atopy (personal or first degree relative) • Eosinophilic inflammation (serum, FeNO, BAL) • Sensitisation (IgE/RAST/skin prick test)	NO

More like pre-school asthma

Less like asthma, more like pre-school episodic wheeze

Physical examination

Assess if the child looks well, check their weight and height, plot their centile and look for any signs of faltering growth. Accurate weight and height will be useful in future for calculating predicted peak flow and it is important to monitor growth for children on inhaled cortico-steroids.

Check for finger clubbing, wet cough, vomiting and any other signs of alternative diagnosis. Refer the child to their GP if you have any concerns.

If you are trained to, listen to the child's chest. If they are symptomatic when you listen, you may hear an expiratory polyphonic (multiple pitches and tones on the out breath) wheeze over different areas of the lung.

Watch this video to hear lung sounds associated with asthma.

Safety note: this video is for information only and does not constitute training

Review the child's notes

Most NHS IT systems allow you to make searches of your patient's notes. This is quick and easy to do and can help you find information you can use to decide if someone is more or less likely to have asthma. Look for:

- GP practice or out of hours/ ED attendance with an acute chest symptom.
- Previous chest symptoms, including any chest infections.
- A record of an HCP hearing a wheeze.

Look in the medications list. Has the child ever been prescribed any

- Inhalers
- Oral steroids (prednisolone)
- Antibiotics for chest symptoms
- Treatment for allergies or eczema?

Document your assessment of the child and if you think that asthma is more likely than preschool wheeze, code the child as ‘suspected asthma’. You can then consider starting treatment.

The purpose of a trial of treatment is to see if it helps with the symptoms, and if they come back after the trial is stopped. A positive response (improved symptoms) suggests the child may have asthma and would likely benefit from ongoing preventer treatment.

If there’s no clear improvement, it may suggest an alternative cause, or the symptoms may be virus-related and not due to underlying asthma. Stopping the trial and assessing the child’s response ensures that the child is not over treated.

This does not confirm a diagnosis of asthma. This can only be done using objective tests when the child is older.

Starting a trial of treatment

Criteria for a trial of treatment - NICE guideline

If the child has symptoms at presentation that indicate the need for maintenance therapy (for example, interval symptoms with another atopic disorder)

or

severe acute episodes of difficulty breathing and wheeze (for example, requiring hospital admission, or needing 2 or more courses of oral corticosteroids)

If the child meets this criteria, start an 8–12 week trial of twice-daily paediatric low dose ICS, with short-acting beta2 agonist (SABA) for symptom relief. Explain that the child has 'suspected asthma' and will need to do tests once they are old enough to do the tests to confirm the diagnosis.

Children aged under 5 should be given pMDI inhalers with a spacer. Children should move from a spacer with a facemask to a spacer with a mouthpiece as soon as they can drink through a straw.

Demonstrate how to use the inhaler and remember to give an additional SABA and spacer for the child to take to any childcare settings they attend. If the child lives between two homes, you may want to prescribe an additional ICS, SABA and spacer.

Give the child an asthma action plan and upload a copy to their notes. Make sure that their parent or carer knows to share the action plan with anyone who provides care for the child.

Discuss triggers, and how to minimise contact with them, including exposure to cigarette smoke, vaping and air pollution.

For extra support, signpost the family to the A+LUK Helpline and Parent and Carer Network. Laura King and Bart’s Charity have produced a comprehensive information pack for parents and carers, with animations, all of which are available in a range of languages.

Explaining a trial of treatment to families

When young children have ongoing cough, wheeze, or breathing difficulties, it can be hard to know if they have asthma. This is because young children often get colds and viruses that can cause similar symptoms, and they are too young to do breathing tests.

A trial of treatment with a low dose of inhaled steroid (often called a 'preventer' inhaler) can help work out whether your child's symptoms are due to asthma. Steroid inhalers are safe, reduce inflammation in the airways and can help prevent symptoms like wheezing and coughing.

If your child's symptoms improve during the trial, this might mean that asthma may be the cause. We will discuss with you at this point whether we stop the inhaler and wait and see if the symptoms return, or whether we continue treatment.

If your child's symptoms don't improve, or only partially improve, we may stop and look at other reasons for your child's symptoms.

The trial is usually for about 8-12 weeks, and it's important to give the inhaler every day as prescribed. You will have a follow-up appointment to review how your child is doing.

Please keep a symptom diary or record your child's symptoms on your phone to hare at the review appointment. You can contact the GP practice or the A+LUK Helpline if you need any extra support in the meantime.

Reviewing the trial of treatment

After 8–12 weeks, if symptoms resolve

- Consider stopping the ICS and SABA and review the child after 3 months to see if symptoms recur.
- Make sure the child's family understand to bring the child back for an earlier review if their symptoms get worse, or they are worried.

If symptoms have not resolved during the trial

- First of all check adherence, inhaler technique and any other factors that might be affecting their asthma control. If you find any issues, correct them and repeat the trial of treatment.
- Review the diagnosis: could it be viral wheeze, GORD, or something else?
- If none of these factors explain why the trial has not worked, refer to a specialist in asthma care.

If symptoms recur after stopping ICS or the child has a severe episode requiring oral corticosteroids or hospitalisation

- Restart the paediatric low-dose ICS twice daily and continue SABA as a reliever.
- Titrate up to a moderate paediatric dose if needed.

Review the child within 12 months and consider trialling without treatment again, in case the cause of the child's symptoms has resolved as they have grown, and they no longer need treatment.

If suspected asthma is uncontrolled

Defining uncontrolled asthma (NICE, 2024)

Any exacerbation requiring oral corticosteroids or frequent regular symptoms such as:

- using reliever inhaler 3 or more days a week

  or

- nighttime waking 1 or more times a week

If the child's suspected asthma is not controlled, and you have checked adherence, inhaler technique and any other factors that might be affecting their asthma control

- Keep the child on their ICS and SABA regime and add in a trial of a leukotriene receptor agonist (LTRA, also known as Montelukast) for 8–12 weeks.

Montelukas is taken at night time in tablet form. Ask the child's parent/carer to keep a symptom diary during their trial of treatment. Make sure they know to return if they have any side effects that are worrying them and ensure that you inform the family of the potential for mental health side effects. Report Montelukast adverse effects using the Yellow Card system.

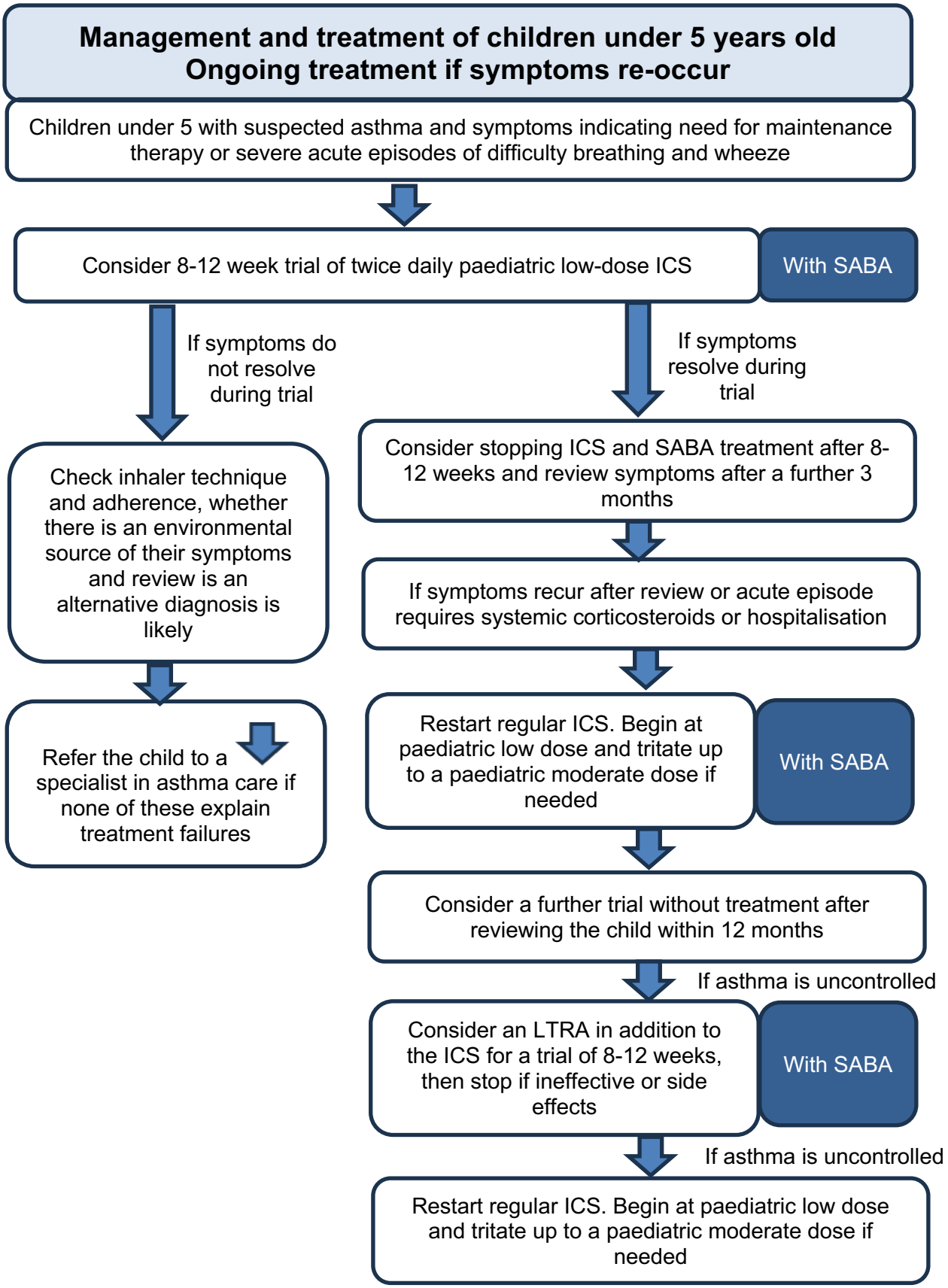
If it is not helping or there are side effects

- Stop the LTRA after (or during) the trial.

If asthma remains uncontrolled

- Stop the LTRA and refer the child to a specialist in asthma care for further investigation and management.

This process is shown in the diagram below:


Management and treatment of children under 5 years old
Ongoing treatment if symptoms re-occur
Children under 5 with suspected asthma and symptoms indicating need for maintenance therapy or severe acute episodes of difficulty breathing and wheeze
Consider 8-12 week trial of twice daily paediatric low-dose ICS
With SABA
If symptoms do not resolve during trial
If symptoms resolve during trial
Check inhaler technique and adherence, whether there is an environmental source of their symptoms and review is an alternative diagnosis is likely
Refer the child to a specialist in asthma care if none of these explain treatment failures
Consider stopping ICS and SABA treatment after 8-12 weeks and review symptoms after a further 3 months
If symptoms recur after review or acute episode requires systemic corticosteroids or hospitalisation
Restart regular ICS. Begin at paediatric low dose and tritate up to a paediatric moderate dose if needed
With SABA
Consider a further trial without treatment after reviewing the child within 12 months
If asthma is uncontrolled
Consider an LTRA in addition to the ICS for a trial of 8-12 weeks, then stop if ineffective or side effects
With SABA
If asthma is uncontrolled
Restart regular ICS. Begin at paediatric low dose and tritate up to a paediatric moderate dose if needed