

Last Name _____ First Name _____ Birthdate _____ Sex _____

High School Tel # (631) 968-1166 Fax # (631) 968-2581 / Middle School Tel # (631) 968-1218 Fax # (631) 968-0391

ASTHMA SPORT/PHYSICAL EDUCATION CLEARANCE

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

DIAGNOSIS: ASTHMA YES () NO ()

INHALER: YES () NO ()

Name of medication _____

Prescribed dosage, frequency and route of administration _____

Time to be taken during school hours: _____ Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

SELF-MEDICATION RELEASE

The above named child has been instructed in the proper use of the above medication procedures.

_____ is permitted to carry the medication with him/her, or to keep
(child's name)

medication in his/her school or P.E. locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use.

() NO RESTRICTIONS-CLEARED FOR P E & SPORTS

() CLEARED FOR P E ONLY

() NO P E / SPORTS UNTIL _____
date

() MODIFIED P E

Parent/Guardian Signature: _____ Date: _____

NAME OF LICENSED PRESCRIBER AND TITLE (Please Print): _____

Prescriber's Signature: _____