Bay Shore Union Free School District
Department of Health, Physical Education and Athletics

SPORT:______________
Grade: _______________

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: ____ Date: ________________________

Address: ____ Phone:________________________

Physician's Stamp:

5/08