**Bay Shore Union Free School District** **SPORT:_____**
**Department of Health, Physical Education and Athletics** **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