SACRED HEART SCHOOL

RELIGION ♥ ACADEMICS ♥ ATHLETICS

HEALTHCARE PROVIDER WRITTEN CERTIFICATION FOR STUDENT W/ASTHMA

The undersigned is the Healthcare Provider for the following student: Student is in Grade:

The undersigned is a (check one box), who provides medical treatment to the above named child and certifies that the patient is being treated by me for Asthma.

☐ Physician ☐ Physician Assistant

With regard to such treatment, the following medication has been prescribed:

The prescribed dosage of such medication is as follows:

The time(s) at which the medication shall be taken is:

Special circumstances, if any, under which the medication is also to be administered is as follows:

My patient is able to self-administer the above referenced medication in the prescribed dosage and at the prescribed times as outlined above.

Company Name, Address & Phone Number of Healthcare Professional:

_____ _____

Signature of Healthcare Professional Date

Printed Name: