SCHOOL HEALTH SERVICES

Student_____Grade/Teacher_____Date_____

Dear Parent/Guardian:

Your child is listed as having asthma. In order to provide comprehensive, individualized care for your child, the following information is needed:

- TYPE OF ASTHMA_____DATE OF LAST EPISODE_____
- ASTHMA IS TRIGGERED BY:
  - ALLERGIES_____
  - EXERCISE_____
  - WEATHER_____
  - OTHER_____
- PEAK FLOW_____
- MEDICATIONS_____
- RESTRICTIONS IN SPORTS, PHYSICAL EDUCATION, OR RECESS:
  _____
- HOW DO YOU WANT THE SCHOOL TO TREAT AN ACUTE EPISODE?
  _____

Please notify the School Nurse if there is any change in condition, medication or treatment.

Please have your child's physician complete the certificate for medication administration and return all information to the Health Suite.

UPPER MERION AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Physician's Certificate for Medication taken During School Hours

Student's Name_____ Grade _____ Age_____

Address_____

Name of Medication _____ Strength_____

Directions for Dispensing_____

Possible Side Effects_____

Effective Dates: From_____ To_____

ALL MEDICATION ORDERS EXPIRE THE LAST DAY OF CURRENT SCHOOL YEAR

Physician's Signature_____ Phone_____

Printed Name of Physician_____

Parent's Signature_____