

**Written Certification from Licensed Healthcare Provider
for
STUDENT with ASTHMA**

1. The undersigned is the healthcare provider of _____.
2. The undersigned is a ____Physician or ____Physician Assistant, who provides medical treatment to the above named child.
3. The patient, _____, is being treated by me for Asthma.
 - a) With regard to such treatment, the following medication has been prescribed:

 - b) The prescribed dosage of such medication is as follows:

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

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

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

Date: _____

Signature of Healthcare Professional

Printed Name of Healthcare Professional

Name of Office of Healthcare Professional

Office/Company Address

Phone Number of Healthcare Professional