UPPER PERKIOMEN SCHOOL DISTRICT

2229 East Buck Rd, Pennsburg PA 18073

Student Name: ___________________________________

Dear Parents/Guardian, Date of Birth: _____________ Grade: ______

If you have stated on your child's emergency card and/or it is noted on his/her health record that he/she has **asthma:**

1. Does this remain a current problem? Yes No (Circle one)
2. Does it require the use of an inhaler? Yes No (Circle one)

If **your child needs to take medication (prescription or over-the-counter) in school, the Upper Perkiomen School District requires that a current physician's order be submitted each year for the student's health record.** ***As a reminder, this includes Analgesics such as Tylenol and Ibuprofen (School Stocks Tylenol 325 mg tablets & Ibuprofen 200 mg tablets)*****. Please have your physician complete the form below only if a medication is needed for use in school. (This can serve as the order/prescription).**

Medication: ____

Dose: ____ Frequency: ___________________________

Reason for medication: ____

Physician's Signature: ____ Date: ___________________

Physician's Printed Name: ____

Physician's Phone #: ____

The student has been taught to use the inhaler and MAY CARRY and self-medicate _______________________________
Physician's Initials

All medications must be in the original container with the student's name and correct dose on the label. **Please return this information, along with the above medication, to the school nurse as soon as possible. Students are not permitted to carry medication to/from school for any reason unless a physician has signed above and student is of appropriate age to do so.** If you have any questions, please call the nurse at your building.

To Be Completed by Parent/Guardian: As parent/guardian of the above named student, I **hereby request that the treatment described above be administered to my child and release the Upper Perkiomen School District and its employees from liability for any damages my child may suffer as a result of this request.**

Parent Signature: ____ Date: ______________

This document contains personal confidential medical information. Please use this form accordingly. Please do not disclose personal confidential medical information or allow this form to be viewed by individuals not authorize to do so.