

Spring Branch Independent School District  
**HEALTH SERVICES**

Physician's Statement for Student Held EpiPen

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

It is necessary that the following medication be administered during school hours as specified in order to maintain this child's physical health and support school performance. I agree to the terms of the contract listed below:

**NAME OF MEDICATION** \_\_\_\_\_ **DOSAGE** \_\_\_\_\_

**TIME** \_\_\_\_\_ **FREQUENCY OF USE** \_\_\_\_\_

Condition for which medication is prescribed \_\_\_\_\_

Medication may cause \_\_\_\_\_

Emergency Instructions \_\_\_\_\_

\_\_\_\_\_  
Licensed Health Care Provider's Name (Please Print)

\_\_\_\_\_  
Signature Licensed Health Care Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

**Contract for Special Use – EpiPen**

The student listed above may carry his/her epi-pen according to the physician/parent statements if he/she is in compliance with the conditions listed below:

- The student has demonstrated to the nurse/nurse assistant the correct use of the epi-pen
- The student agrees to never share the epi-pen with another person
- The student agrees that after taking the initial dose prescribed, he/she will go immediately to the health room or have the nurse called to his/her location. EMS will be activated as deemed necessary by the health services staff.
- The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review status

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

I hereby grant permission for my child to carry the EpiPen described above. I understand that he/she must follow the rules listed and I will notify the school of changes in my child's medication and/or condition. If necessary, I also grant permission for the school nurse or other school personnel to administer medication to my child according to the physician's statement above.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email address

Medication must be prescribed by a licensed health care provider and appropriately labeled in the original container by the pharmacy or health care provider.