Spring Branch Independent School District

HEALTH SERVICES

Physician's Statement for Student Held Inhaler

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) | Licensed Health Care Provider's Signature

Address | Telephone | Date

Contract for Special Use – Inhaler

The student listed above may carry his/her inhaler 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 inhaler
- The student agrees to never share the inhaler with another person
- The student agrees that after taking the initial dose prescribed, and if there is not marked improvement, he/she will go immediately to the health room.
- 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 inhaler 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 physician and appropriately labeled in the original container by the pharmacy or physician.

R: 02/13 (jc)