

Spring Branch Independent School District
HEALTH SERVICES
Physician's Statement for Student Held Inhaler

Student's Name _____ Birthdate _____

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 _____

Physician's Name (Please Print)

Physician's Signature (Original)

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.