Spring Branch Independent School District HEALTH SERVICES

Physician's Statement for Student Held EpiPen

maintain this child's physical health and support school performance. I agree to the terms of the contract lis below: NAME OF MEDICATIONDOSAGE TIMEFREQUENCY 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 compli with the conditions listed below: • 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 ser staff. • The student agrees to never share the epi-pen with another person • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assistant to review staff. • The student agrees to keep scheduled monthly appointments with the nurse/nurse assis	Student's Name	Date of Birth	Date of Birth	
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Signature of Parent/Guardian Date Email address	-	Date		

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