Spring Branch Independent School District

HEALTH SERVICES

Physician's Statement for Medication Administration through Use of Patch

Student's Name_____ Birthdate_____

School_____ Grade_____

It is necessary that the following medication via a medication patch be used /administered during school hours as specified in order to maintain this child's physical health and to 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 – Medication Administration through Patch

The student listed above may wear the prescribed medication patch 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/wearing of the medication patch.
- The student agrees to never remove, change, or in any way adjust the patch without the direct supervision of the school nurse, nurse assistant, or other qualified school health personnel in the Health Room.
- The student acknowledges that the patch will not be handled, touched, or shared with another person.
- The student agrees that he/she will go immediately to the health room if significant side effects are experienced during the normal course of wearing the medication patch.
- The student agrees to meet with the nurse/nurse assistant to review status of this medication as needed.

_____ _____

Signature of Student Date

I hereby grant permission for my child to wear the medication patch described above during school hours. 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.

I further acknowledge that our physician has discussed with us the appropriate use and possible side effects of this medication and that we have provided a copy of these to the school. We will monitor and share with school health services personnel any concerns that may arise from the use of this medication patch.

_____ _____

Signature of Parent/Guardian Date

Email address_____

R: 09/21 (ch)