

Crandall Independent School District
Annual Health Services Prescription
Physician/Parent Authorization for Allergy/ Anaphylaxis Management

*This form is to be renewed at the beginning of each school year
 For children with multiple severe allergies, use one form for each allergy.

ALLERGY TO: _____

Student name: _____ Grade: _____ DOB: _____

Parent name: _____ Phone (H): _____ (W) _____

Physician name: _____ Phone: _____ Hospital: _____

Asthmatic? Yes (High risk for severe reaction) No

<u>Systems</u>	<u>Possible Symptoms:</u>
MOUTH	<i>itching & swelling of the lips, tongue, or mouth</i>
THROAT*	<i>itching and/or sense of tightness in the throat, hoarseness, & hacking cough</i>
SKIN	<i>hives, itchy rash, &/or swelling about the face or extremities</i>
ABDOMIN	<i>nausea, abdominal cramps, vomiting, &/or diarrhea</i>
LUNG*	<i>shortness of breath, repetitive coughing, &/or wheezing</i>
HEART*	<i>"thready" pulse, "passing-out"</i>

The severity of symptoms can quickly change. ***All above symptoms can potentially progress to a life-threatening situation. Do not hesitate to call 9-1-1!**

TO BE COMPLETED BY THE PHYSICIAN

The parent/guardian of the above named student has notified the school that this student has a potentially life-threatening allergy and will require an EpiPen® at school, in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

Action Plan for Known/Suspected Sting (Bite)/Ingestion/Inhalation

ACTION FOR MINOR REACTION

Probable symptoms for this student include _____

1) Administer _____ medication/dose/route

2) Contact Parents or emergency contacts.

*If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

Probable symptoms include _____

1) **IMMEDIATELY!** Administer _____ medication/dose/route

2) Call 9-1-1 & tell them it is life-threatening.

3) Contact Parents or emergency contacts.

4) Contact Physician.

FOR SELF-ADMINISTRATION ONLY

Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself?
 Yes ___ No ___

Has this student been trained in the signs and symptoms of minor and major reactions? Yes ___ No ___

Is this student capable of self-administering EpiPen®? Yes ___ No ___

Can this be safely self-administered in the school setting? Yes ___ No ___

Does this student need the supervision of a designated adult? Yes ___ No ___

Has the student been trained in the self-administration of the EpiPen®? Yes ___ No ___

Physician's Signature: _____
 Date : _____ Physician's Name: _____
 Phone: _____
 Address: _____ Fax _____

TO BE COMPLETED BY THE PARENT

I, the undersigned, parent/guardian of _____ request that an EpiPen® be administered to my child, as prescribed by the physician. I understand that the school administration will designate trained staff to perform this procedure. It is my understanding that in performance of the procedure, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I also give my consent to release medical/health records and permission for appropriate school staff to contact the physician/health care provider for additional information if needed.

Parent’s Signature: _____ Date: _____

FOR SELF-ADMINISTRATION ONLY

I, the parent/guardian of _____ request that he/she be allowed to self-administer the EpiPen®. I understand that the school administration will designate trained staff to monitor the procedure. It is my understanding that in performing this procedure my child will be using a standardized procedure that has been approved by the physician.

Parent’s Signature: _____ Date: _____

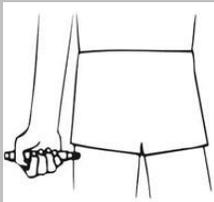
EMERGENCY CONTACTS

- 1. _____ Relation: _____ Daytime phone _____
- 2. _____ Relation: _____ Daytime phone _____
- 3. _____ Relation: _____ Daytime phone _____

FOR OFFICE USE ONLY

How to Use an Epinephrine Auto-Injector

- 1. Pull off gray safety cap
- 2. Place black tip on outer thigh (always apply to thigh)



- 3. Using a swing and jab motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10.
- 4. Remove and bend needle back on hard surface. Place back in plastic tube and send EpiPen® with patient to hospital.

MEMBERS

- 1. _____
- 2. _____
- 3. _____