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 ☐

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

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 trained and 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___

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:_____

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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.

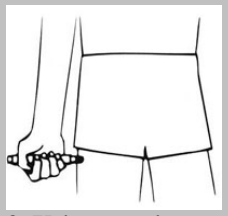
Parent's Signature: _____ Date:_____

## 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. _____
4. _____