EL PASO COUNTY SCHOOL HEALTH SERVICES
PRACTITIONER'S WRITTEN ORDER/ALLERY/ANAPHYLAXIS PLAN

If medication and/or a health care procedure is to be administered during regular school hours for illness or disability, it is necessary for the District to receive the following:

1. A Practitioner's Written Order statement dated for the CURRENT school year signed by the parent, legal guardian or other person(s) having legal authority of the student AND the attending practitioner licensed to practice medicine in the state of Texas. (Exception: U.S. Military)
2. Original container with prescription label from a registered pharmacist licensed to practice in the state of Texas with current date, student's name, dose to be given, time(s) to be given, and medication route to be given.
3. The student is not allowed to carry his/her own medication or to self-administer the medication unless ordered by the licensed practitioner.
4. ONLY medications and/or health care procedures prescribed in writing by the attending practitioner licensed to practice medicine in the state of Texas are to be administered. The following will not be administered by any school personnel: Medication prescribed and/or purchased in foreign countries, herbal, alternative, or non-traditional preparations.

All Nurses wherever employed must observe the law that requires them to have a written practitioner's order before the administration of any medication

AT THE END OF THE SCHOOL YEAR, ALL UNCLAIMED MEDICATION WILL BE DESTROYED ON THE LAST DAY OF SCHOOL.

COMPLETE AND RETURN THIS FORM TO THE SCHOOL NURSE

Name of Student _____ DOB _____ I.D.# _____ Grade _____

School Year 20 _____ -20 _____ School Name _____

I. TO BE COMPLETED BY A LICENSED PRACTITIONER

Allergic to: _____

Asthmatic: ☐ Yes ☐ No (Yes: higher risk for severe reaction)

If allergen has been ingested or suspect ingestion/exposure:

Symptoms		**Give Checked Medication** Physician authorized treatment	
	☐ No symptoms	☐ Epinephrine	☐ Antihistamine
Mouth	☐ itching, tingling sensation, swelling of lips, tongue, mouth, or drooling	☐ Epinephrine	☐ Antihistamine
Throat	☐ swelling of tongue and throat, difficulty swallowing, itching, tightness/closure, hoarseness, changes in voice	☐ Epinephrine	☐ Antihistamine
Skin	☐ hives, itchy rash, redness, swelling	☐ Epinephrine	☐ Antihistamine
Gut	☐ nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Lungs	☐ respiratory difficulty, shortness of breath, cough, shallow respirations, wheezing, stridor	☐ Epinephrine	☐ Antihistamine
Heart	☐ weak or thready pulse, heart palpitations, drop in blood pressure, dizziness, lightheadedness, loss of consciousness	☐ Epinephrine	☐ Antihistamine
	☐ Other	☐ Epinephrine	☐ Antihistamine
	☐ If reaction is progressing (several of the above area affected) give:	☐ Epinephrine	☐ Antihistamine

Dosage

Epinephrine Inject intramuscularly (***circle appropriate dose***) Epinephrine injection, auto-injector: 0.3 mg / 0.15 mg

Antihistamine _____
Medication/Dose/Route

Other _____
Medication/Dose/Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

I understand that the emergency medication listed above may be administered by a trained unlicensed staff member and that 911 will be called whenever the above emergency medication is given. In addition for my patient I would like to add the following _____.

☐ Yes ☐No The above named student is capable of self-administration and should carry his/her own medication.

_____ _____ _____ _____
Printed Name of Practitioner | Practitioner's Signature | Telephone Number | Date

_____
FAX

II. PARENT/GUARDIAN SECTION

Parent/Guardian Authorization and Responsibility: I, the undersigned, parent/guardian of the above named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider for my child in accordance with state laws and regulations. I understand medication may only be administered by licensed health professionals, and trained unlicensed personnel, according to state laws and regulations. I also understand that prescribed emergency medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task and 911 will be called immediately following the administration of any emergency mediation.

I agree to:
1. Notify the school nurse if any emergency medication was administered to my child within 12 hours of attending school.
2. Notify the school nurse if there are any changes in my child's medical condition and/or treatment plan.
4. Maintain current phone numbers with the school nurse and school office in case 911 is called.
5. Provide the necessary medication, supplies, and equipment for my child's treatment while at school.

Parent /Guardian Authorization for School Staff to Communicate Health Information
I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my child's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, and medical treatments. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate.

_____ **Parent/Guardian initials** I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's Allergy and authorized medication when necessary.

☐ **Yes** ☐ **No I give permission for my child to carry his/her epinephrine pen, in accordance with the physician's instructions above.**

Parent/Guardian Signature: _____ Date: _____

II. SECCION DE PADRE O TUTOR

Responsabilidad de Padre/Tutor: Yo, el abajo firmante, padre o tutor del estudiante nombrado arriba, solicita que sea realizado todos los procedimientos y la administración de medicamento según lo autorizado por el proveedor de salud de mi hijo de acuerdo con las leyes y reglamentos estatales. Entiendo que el medicamento sólo puede ser administrado por profesionales de salud licenciados y personal sin licencia que ha sido entrenado conforme a las leyes y reglas estatales. También entiendo que el medicamento prescrito de emergencia solo se puede administrar a mi hijo/a por una enfermera escolar o por mí hasta que personal de la escuela complete el entrenamiento requerido por el Distrito. En ausencia de una persona con licencia médica como una enfermera escolar, sólo el personal capacitado estará autorizado a realizar esta tarea y 911 será llamado inmediatamente después de administración de cualquier medicamento de emergencia.

Estoy de acuerdo en:
1. Notificar a la enfermera si el medicamento de emergencia fue administrado a mi hijo dentro de 12 horas de asistir a la escuela.
2. Notificar a la enfermera si hay algún cambio en la condición médica de mi hijo y/o el plan de tratamiento.
3. Mantener los números de teléfono actuales con la enfermera o la oficina escolar en caso de que se llama al 911.
4. Proporcionar el medicamento, suministros y equipos necesarios para el tratamiento de mi hijo/a en la escuela.

Autorización del padre de familia/tutor para que el Personal Escolar Comunique los Datos Médicos
Autorizo a los representantes del Distrito, incluyendo los profesionales médicos y UAPs del Distrito, a compartir con el profesional médico o proveedor de salud mencionado en la parte superior a obtener datos médicos de mi hijo/a al fin de planificar, implementar o aclarar las acciones necesarias en la administración de servicios escolares relacionados con la salud, que incluyen pero no se limitan a: atención de urgencia, cuidado para cualquier diagnóstico, o tratamientos médicos. Al firmar esta Autorización reconozco que la información usada o divulgada referente a los Datos Médicos personales e Identificables de mi hijo/a puede ser sujeto a re-divulgación por el personal autorizado y a las personas cual ellos se comuniquen.

_____ **Iniciales del Padre/Tutor**

☐ **Si** ☐ **No** **Doy permiso para que mi hijo/a cargue su pluma de epinefrina, de acuerdo con las instrucciones del médico delineadas arriba.**

Firma del Padre/Tutor: _____ Fecha: _____