DALLAS INDEPENDENT SCHOOL DISTRICT | Health Services

PHYSICIAN/PARENT REQUEST FOR
ADMINISTRATION OF ANAPHYLAXIS MEDICINE BY SCHOOL PERSONNEL

FILED IN NURSE'S OFFICE ON _____ BY _____

Special health care procedures and medications may be administered at school by designated employees of the district when such treatment is necessary for school attendance. Medication or special procedure may be administered by a school nurse or employees designated by the principal. The medication is administered either from a container that appears to be the original container and properly labeled by the pharmacy or from a properly labeled unit dosage container filled by a school nurse or designated district employee. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent.

THIS INFORMATION IS CURRENT UNTIL NEW OR UPDATED INFORMATION IS RECEIVED OR FOR ONE CALENDAR YEAR FROM DATE OR UPDATE OF REQUEST.

1. Name of Pupil_____ Birth Date_____
2. Address_____ School_____
3. Condition for which prescribed treatment is required:_____ ICD 10 Code_____
4. Asthmatic (Severe reaction): ☐ Food Allergy: ☐ Other allergy: _____
5. Allergic Symptoms: (circle symptoms that apply)

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GI	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive, coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	_____

Dietary order is required for all food allergies. Form is located at www.dallasisd.org /page/930

6. Medication orders: ☐ EpiPen (.3) ☐ EpiPen (.15) ☐ Other _____ Repeat dose: ☐ If so, when: _____
   Antihistamine:_____
7. Precautions, unfavorable reactions:
   ☐ Self-Administration/self-carry of Asthma or Anaphylaxis Medicine
8. Disposition of pupil following administration or procedure, if applicable, i.e., rest, home, hospital, doctor's office, return to class.
9. Date of Request_____ Date of Termination_____

_____/_____
Physician's Name (printed) *Signature*

_____/_____
Physician's Address *Telephone Number*

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We (I), the undersigned, the parents/guardians of _____ request the above medication or procedure be administered to our (my) child. We (I) authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

Nosotros, los padres/los tutores de _____ solicitamos que el medicamento o procedimiento anterior se administre a nuestro (mi) hijo. Nosotros (yo) autorizamos según sea necesario el intercambio de infomación relacionada con la salud de mi hijo entre la enfermera de la escuela (o su designado) y el proveedor de atención médica mencionado anteriormente.

_____/_____ Telephone _____/_____
Name *Relationship* *Home* *Business*

_____/_____ Telephone _____/_____
Name *Relationship* *Home* *Business*

NOTE: Prescribed asthma or anaphylaxis medicine may be kept and self-administered by the student if the physician indicates this in writing and student is capable of self-administration.

MEDICATION OR SPECIAL PROCEDURE RECORD ADMINISTRATION

(This record is used by non-Health Services personnel administering medication/special procedures during the school day or field trips.)

Student's Name_____ Grade_____ School_____ School Year_____

Medication/Procedure_____ Dosage_____ Time(s)_____

After administering medication/special procedure, initial in the appropriate space. Use a separate form for each medication or procedure. Medications or special procedures that will be current for the next school year are to be kept in the Medication Notebook. Record the medication or procedure in the student's electronic health record daily. If indicated place a copy in the student's special education Individual Education Plan.

Codes: A = Absent, X = No School, M = Missed, N = No Medication, R = Refused *Shaded area in date box is for medication count.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Name	Initials	Name	Initials	Disposition:	Date
				Medication/procedure discontinued	
				Medication/special equipment returned to parents	
				Medication disposal	