HEALTH SERVICES

RICHARDSON INDEPENDENT SCHOOL DISTRICT

RISD ~Where all students learn, grow, and succeed.

Dear Parents,

You are receiving this letter because you have indicated your child has a severe allergy. Enclosed are forms that are required by RISD to be completed by you and your child's physician. To ensure quality care is given to your child please make certain you return all required forms indicated in the checklist below to the school nurse. The forms are to be renewed each year. Please note that some forms require a physician's signature.

When you have obtained all of the required forms, please call the school nurse to schedule a meeting to discuss and develop an individualized healthcare plan and emergency allergy action plan for your child.

All students with severe allergies must provide:

- ☐ Physician/Parent Authorization for Anaphylaxis Management -**Physician's Signature Required**

If your child will have emergency medication at school, you are also required to provide:

- ☐ *Parent/Physician Request for Administration of Medication by School Personnel* form(each medication requires a separate form)
- ☐ Physician ordered medication(s) in the original container; prescription medications must also have the prescription label(s) attached.

If your child has a severe *food* allergy, you will also need to provide:

- ☐ Severe Food Allergy Questionnaire
- ☐ RISD Standard Food Substitution Form – **Physician Signature Required**

Thank you,

RISD Health Services

HEALTH SERVICES
Richardson Independent School District
Annual Health Services Prescription
Physician/Parent Authorization for Anaphylaxis Management
*This form is to be renewed annually.

Student name: ____ Grade: ________ DOB: ________________

SEVERE ALLERGY TO:____

Weight: _________lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

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 epinephrine at school, in the event of an emergency. Please complete this form based on your examination and knowledge of this student and sign in the space provided.

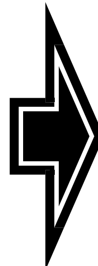
Any SEVERE SYMPTOMS after suspected or known ingestion, sting/bite:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

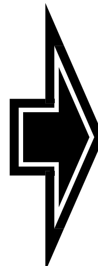


1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications. *
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort
OTHER: ________________________________



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert school nurse and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

ADDITIONAL SECTION FOR STUDENTS WITH **FOOD** ALLERGIES (*OPTIONAL DEPENDING ON SEVERITY OF ALLERGY*)

Extremely reactive to the following foods: ____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

MEDICATIONS/DOSES

Epinephrine (brand and dose): ____
Antihistamine (brand and dose): ____
Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

MONITORING

Stay with student; alert school nurse and parent. Tell EMS epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

Continued next page

TO BE COMPLETED BY THE PHYSICIAN:

Does this student have physician permission to self-administer this medication & to carry it on himself/herself?.... ☐ Yes ☐ No

If No, skip to next section (Physician signature)

Has this student been trained in the signs and symptoms of mild and anaphylactic reactions? …………………… ☐ Yes ☐ No

Is this student capable of self-administering the epinephrine auto-injector? ……………………………………….. ☐ Yes ☐ No

Can this safely be 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 epinephrine auto-injector? …………………………... ☐ Yes ☐ No

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When prescribed (and provided to the school by the parent), epinephrine will be administered according to manufacturer directions.

Physician's Signature: ____ **Date**: ____________________

Physician's Name: ____ Phone: ____________________

Address: ____ Fax: ____________________

TO BE COMPLETED BY THE PARENT/GUARDIAN

My child rides the bus to/from school. ☐ Yes ☐ No

I, the undersigned, parent/guardian of ______________________________ request that an epinephrine auto-injector be administered to my child as prescribed by the physician. I understand that it is my responsibility to provide the prescribed medications to the school in order for the treatment prescribed by my physician above to be provided by district personnel. 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 the standardized procedure per the epinephrine injector manufacturer directions 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/healthcare 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 epinephrine auto-injector. 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 the standardized procedure per the epinephrine injector manufacturer directions that has been approved by the physician. I also understand that RISD reserves the right to require that this medication be kept in the clinic if, in the school nurse's judgment, the student cannot or will not carry the medication in a safe manner and properly self-administer the medication.

My child will keep the epinephrine auto-injector in his/her: ☐ Backpack ☐ Purse ☐ Locker ☐ Other: ____________ while at school.

Parent's Signature: ____ Date: ____________________

Emergency Contact Information

		Home:	Work:	Cell:
Mom/Guardian:				
Dad/Guardian:				
:				
:				

2017-2018

HEALTH SERVICES

Richardson Independent School District

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: ________________ **School:** ______________________ **Teacher/Grade:** _____________________

Student's Name: ____ **Birth date:** _____/______/__________

Medication: ___________________________________ **Exp. Date**_________ **Dosage:** ________________________

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: ________________________________ **Dates to be Administered:** ___________________

Condition for which medication is required: ____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____________________________________

Special Instructions or known Side Effects of medication on your child: ___________________________________

____

Please indicate how you would like the medication to be returned home:

☐ Send home in my child's backpack* ☐ Parent/Guardian will pick up med from clinic ☐ Do not return med, please discard any remaining doses

**Controlled substances (such as Ritalin, amphetamine salts, etc.) must be transported by a parent/guardian and will not be released to students.*

The district will take reasonable measures to store medication at ambient room temperatures unless refrigeration is required. Parents must take home medications during school breaks to avoid exposing medications to extreme heat or cold.

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time.

Parent/Guardian Signature: ________________________________ **Email:** ___________________________________

Parent's Primary Phone: (_____)__________-_________________ **Alternate Phone:** (_____)_________-___________

Physician's Name: ____ **Phone:** (______)________-_________________

**A physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the physician's signature below.*

***Physician's Signature:** ____

FOR OFFICE USE ONLY!

☐ Entered in Focus

☐ Teacher Notified ___/___

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student ____ Date ________________

Parent/Student Signature

HEALTH SERVICES
Richardson Independent School District
Severe Food Allergy Questionnaire

Dear Parent/Guardian,
Thank you for completing the questionnaire below regarding your child's severe food allergy. This information is important for the nurse to have in order for him/her to develop an individualized healthcare plan for your child. This plan is used to coordinate the safe care of your child while at school.

Student: ______________________ Date of Birth: ____/____/______ Gender: ☐ Male ☐ Female

Severe Allergy to: ____

Has your child been diagnosed with asthma or eczema in addition to a severe allergy? ☐ Asthma ☐ Eczema ☐ Neither

At what age was the food allergy first noted? ______________________

Please describe the incident leading to the diagnosis of severe food allergy.

____
____
____
____

Has your child ever received an epinephrine injection (such as EpiPen) during an allergic reaction? ………………... ☐ Yes ☐ No

When was your child's last reaction? ______________________

When was the last time the physician tested your child's sensitivity level to the allergen? ______________________

What type of exposure is necessary for an allergic reaction to occur? ☐ Ingestion ☐ Contact ☐ Inhalation

Does your child know when he/she is having an allergic reaction, and are they able to tell an adult? ………………... ☐ Yes ☐ No

How does your child act and what do they say when they are having symptoms of an allergic reaction? ______________________

____
____
____

Do you feel your child has a good understanding about their allergy and which foods they should not eat or touch?....... ☐ Yes ☐ No

Does your child wear an allergy alert bracelet or necklace? ………………………………………………………… ☐ Yes ☐ No

Do you prefer that your child sit at a designated peanut and nut free table in the cafeteria? …………………………….. ☐ Yes ☐ No

Is your child emotionally sensitive about his/her allergy, or has he/she ever been bullied about allergies? ……………… ☐ Yes ☐ No

Do you give permission for us to send home a letter to your child's class notifying parents about this food allergy (child is not identified)? ………………………………………………………………………………………… ☐ Yes ☐ No

Additional information: ____

____
____
____

Parent Signature: ______________________ **Date:** ______________

CHILD NUTRITION
RICHARDSON INDEPENDENT SCHOOL DISTRICT

Standard Food Substitution Form

*This form is to be completed annually by a licensed physician for students with life-threatening food allergies and other issues such as food intolerances. *Esta forma es realizar anualmente por un médico con licencia para estudiantes con alergias a los alimentos potencialmente mortales y otros temas como intolerancias alimentarias.*

Student Name: ______________________ School: ______________________ School Year: __________

Student ID: __________ Licensed Physician: ______________________________ Date: __________
(Name and Signature)

☐ My child will NOT be eating school prepared meals. ☐ My child WILL be eating school prepared meals.

☐ **No Substitutions Needed**

*Remember, for a life-threatening allergy, meals from home provide the safest option.

To be completed by the Physician:
Please indicate the appropriate allergy and provide substitution guidance.

☐ **Peanut Allergy** ☐ **Tree Nut Allergy**
* RISD does not serve any peanut or tree nut items.

☐ **Milk Protein Allergy** ☐ **Milk (Lactose) Intolerance**
Safe Substitute(s): ☐ Lactaid milk ☐ Water ☐ Other: ______________________

☐ **Dairy/Casein Allergy**
Safe Substitute(s): ☐ Deli turkey ham or turkey meat ☐ Hamburger patty (no bun) ☐ Hotdog (no bun) ☐ Plain pasta
☐ Soft/Crispy taco without cheese ☐ Other: ______________________

☐ **Fish Allergy**
Safe Substitute(s): ☐ Chicken rings ☐ Chicken nuggets ☐ Chicken tenders ☐ Cheese sandwich ☐ Other: __________

☐ **Wheat/Gluten Allergy**
Safe Substitute(s): ☐ Rice ☐ Corn chips/crispy taco shell ☐ Oatmeal ☐ Rice (Crispix) cereal ☐ Plain vegetables
☐ Chef Salad with cheese & egg (gluten free) ☐ Teriyaki chicken (gluten free)
☐ Other: ______________________
*RISD hamburger patty, taco/nacho/chili meat, and spaghetti meat sauce are gluten free.

☐ **Soy Allergy** (most of our foods contain soy or soy oil)
Safe Substitute(s): ☐ Hamburger patty ☐ Turkey hotdog ☐ Deli meat slices ☐ Yogurt ☐ Cheese slices ☐ String cheese
☐ Plain vegetables ☐ Other: ______________________

☐ **Egg Allergy**
Safe Substitute(s): ☐ Sausage patty ☐ Hamburger patty (on bun) ☐ Hotdog (on bun) ☐ Cheese sandwich
☐ Other: ______________________

Additional Foods to Omit: ______________________

____

Additional Foods to Substitute: *some substitutions may not be available or allowed. Substitutions must be products commonly available in a school cafeteria

____

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