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

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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.

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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:				
:				
:				