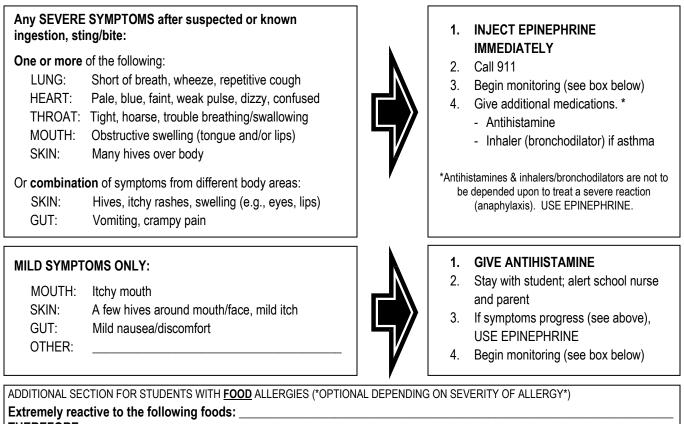
| R              | HEALTH SERVICES<br>Richardson Independent School District<br>Annual Health Services Prescription<br>Physician/Parent Authorization for Anaphylaxis Management<br>*This form is to be renewed annually. |
|----------------|--|
| Student name:  | Grade: DOB:  |
| SEVERE ALLERGY | ′ TO:  |
| 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.



THEREFÓRE:

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.

### TO BE COMPLETED BY THE PHYSICIAN:

| Does this student have physician permission to self-administer this medication & to carry it on himself/herself? 🗌 Yes 📃 N | lo |
|--|----|
| If No, skip to next section (Physician signature)  |    |
| Has this student been trained in the signs and symptoms of mild and anaphylactic reactions?                                | lo |
| Is this student capable of self-administering the epinephrine auto-injector?   | lo |
| Can this safely be administered in the school setting?   | lo |
| Does this student need the supervision of a designated adult?  | lo |
| Has the student been trained in the self-administration of the epinephrine auto-injector?                                  | lo |

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. | ′es 🗌 | 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:

FOR SELF-ADMINISTRATION ONLY

\_Date: \_\_\_\_\_

| I, the parent/guardian of<br>epinephrine auto-injector. I understand that the school administration will des<br>understanding that in performing this procedure my child will be using the<br>manufacturer directions that has been approved by the physician. I also unde<br>medication be kept in the clinic if, in the school nurse's judgment, the stud<br>manner and properly self-administer the medication. | e standardized procedure per the epinephrine injector<br>erstand that RISD reserves the right to require that this |
|--|--|
| My child will keep the epinephrine auto-injector in his/her: Backpack while at school.   | Purse Locker Other:  |

Parent's Signature:

\_ Date: \_\_\_\_\_

| Emergency Contact Information |  | Home: | Work: | Cell: |
|-------------------------------|--|-------|-------|-------|
| Mom/Guardian:                 |  |       |       |       |
| Dad/Guardian:                 |  |       |       |       |
| :                             |  |       |       |       |
| :                             |  |       |       |       |