Austin Independent School District

dell children's medical center of central texas
A member of the Seton Family of Hospitals

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF EPI-PEN AT SCHOOL

(Complete one form for each medication.)

Student Name: ____ Date of Birth: ______________________

School Name: __________________________________ Teacher: ________________________ Grade: ____

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. Children's AISD Student Health Services and AISD require the following:

- Medication is in the original, properly labeled container (name of medicine with strength, dosage and directions; name of prescribing physician who is licensed in Texas; current date). Epipen must not be expired.
- Medication label contains the student's first and last name**.**
- All sharps are to be disposed of in an approved container.

Please complete the following:

Medication Name and Strength	Dosage	Time(s) to be Given at School	Additional Comments

Medication Start Date: ________________________ Medication Stop Date: _________________________

- I request that the above medication be given during school hours as ordered by this student's physician. I also request that the medication be given on field trips, as prescribed.
- I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication.
- I give permission for trained school personnel to assist the student with epi-pen.
- My child ______________________ (circle one) **may/may not** carry the medication home when the school year ends.

IF YOU WANT YOUR STUDENT TO CARRY HIS/HER EPIPEN Children's/ AISD Student Health Services and AISD require the following:

- Written request from parent/ guardian to allow the student to carry the prescribed epi-pen and use without supervision.
- Permission from the school nurse, after assessing the student's knowledge and ability to safely carry and use the epi-pen without supervision.
- WRITTEN AUTHORIZATION FROM THE PHYSICIAN (see below).

I request that my child be permitted to carry the prescribed epipen and to use it without supervision.

Parent/Guardian Signature: ____________________________________ Date: _________________

PHYSICIAN AUTHORIZATION:

□Student is knowledgeable about the epi-pen and understands how and when to use it safely.
□ Student may administer the epi-pen without supervision.
□ Student is not approved to self-medicate.

____
Physician's Printed Name   Office Phone Number   Physician's Signature   Date

Principal or designee notified for self carry: □ Yes □ No

_______________________________________ _____________________ __________________
Parent/Guardian Printed Name   Day Phone   Home Phone

_______________________________________ ___________________________ ______________________
Parent/Guardian Signature   Date   Relationship to Student

Principal/Designee notified of self carry _______yes ________no

Reviewed by RN ___________ SHA _____ may/ _____may NOT administer this medication.
Date

RN PRINTED Name: __________________________________RN Signature: ______________________________

IHCP on file: Yes / No   Form in compliance with SB 27.

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ANAPHYLAXIS/ALLERGIC REACTION INFORMATION FROM PARENT

Student Name_______________________________ Birth Date________________School_______________Teacher/grade___________

Parent/Guardian______________________ Phone (H)____________________Phone(W)_______________Phone(Cell)____________

Parent/Guardian______________________ Phone (H)____________________Phone(W)_______________Phone(Cell)____________

Emergency contact___________________________Relationship______________________Phone_____________________

Physician/Clinic____Phone(office)_____________FAX________

Does your child see another doctor/clinic for anaphylaxis/allergic reaction? (If yes, please complete doctor information)? □Yes □No

Doctor/Clinic____Phone(office)_____________FAX________

List all medications: Home____

School____

What date did you child have their first anaphylactic/allergic reaction?____

How many anaphylactic/allergic reactions has your child had since the first reaction? _______________________________________

When was your child's last anaphylactic/allergic reaction?____

Has your child been hospitalized due to an allergic/anaphylaxis reaction? □Yes □ No

Does your child have an Epi-pen? □Yes □ No

Does your child have asthma? □Yes □ No

What triggers an anaphylaxis/allergic reaction in your child? (Check all that apply)

- □ Bee/Wasp sting
- □ Ant Bite
- □ Other Insect Sting_____________
- □ Peanuts
- □ Tree Nuts
- □ Other Nuts___________________
- □ Wheat
- □ Soy
- □ Milk
- □ Eggs
- □ Fish
- □ Shellfish
- □ Other Foods_________________
- □ Other Foods_________________
- □ Other Foods_________________
- □Plants, flowers, cut grass, pollen
- □ Other______________________
- □ Other______________________
- □ Other: _____________________

Describe the symptoms your child experiences before or during an anaphylaxis/allergic reaction. (Check all that apply)

- □ Hives
- □ Difficulty Breathing
- □ Paleness
- □ Complaint of tingling, itchiness, or metallic taste in the mouth
- □ Vomiting
- □ Cramps/Stomach Pain
- □ Diarrhea
- □ Swelling/itching of the mouth or throat area
- □ Loss of consciousness
- □ Other______________________
- □ Other ______________________
- □ Other_______________________

Authorization for Release of Medical Information:

I hereby authorize____ to furnish anaphylaxis/allergic reaction related information
(Clinic/Provider)

regarding my child ____ to the Student Heath Services personnel at _________________.
Student's Name School

_____________________________________ _______________________________________ _______________________
Parent/Guardian Signature Print Name Date

I give permission for the school nurse to communicate with my child's doctor concerning their anaphylaxis/allergic reaction and its treatment

_____________________________________ _______________________________________ _______________________
Parent/Guardian Signature Print Name Date

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INFORMACIÓN DE LOS PADRES SOBRE REACCIÓN ANAFILÁCTICA / ALÉRGICA

Nombre del estudiante___________________________Fecha de nacimiento_______Escuela_____________Maestro/grado__________

Padre/Custodio legal________________ Teléfono(casa)_________________Teléfono(trabajo)_________Teléfono(Celular)____________

Padre/Custodio legal________________ Teléfono(casa)_________________Teléfono(trabajo)_________Teléfono(Celular)____________

Contacto de emergencia____________________________Relación______________________Teléfono_____________________

Doctor/clínica____Teléfono(oficina)________________FAX_____________

¿Su hijo(a) ve a otro doctor/clínica para reacción anafiláctica/alérgica? (Si es "sí", favor de llenar la información del doctor)? □Sí □No

Doctor/Clínica____ Teléfono(oficina)________________FAX_____________

Lista de todas las medicinas: Casa____

Escuela____

¿En qué fecha tuvo su hijo(a) la primera reacción anafiláctica/alérgica?____

¿Cuántas reacciones anafilácticas/alérgicas ha tenido su hijo(a) desde que tuvo la primera reacción? _______________________

¿Cuándo tuvo su hijo(a) la última reacción anafiláctica/alérgica____

Ha sido hospitalizado su hijo(a) debido a una reacción anafiláctica/alérgica? □Sí □ No

¿Ha tenido su hijo(a) un Epi-pen? □Sí □ No

¿Su hijo(a) tiene asma? □Sí □ No

¿Qué le provoca a su hijo(a) una reacción anafiláctica/alérgica? (Marque todo lo que se aplique)

□ picadura de abeja/avispa
□ picadura de hormiga
□ picadura de otro insecto___________
□ cacahuates
□ nueces de árbol
□ Otras nueces___________________

□ trigo
□ soya
□ leche
□ huevos
□ pescado
□ marisco

□ otros alimentos_________________
□ otros alimentos _________________
□ otros alimentos _________________
□ plantas, flores, recorte de pasto, polen
□ otro______________________
□ otro ______________________
□ otro _____________________

Describa los síntomas que su hijo(a) experimenta antes o durante una reacción anafiláctica/alérgica. (Marque todos los que sean)

□ urticaria
□ dificultad para respirar
□ palidez
□ queja de cosquilleo, comezón, o sabor metálico en la boca

□ vómitos
□ cólicos/dolor de estómago
□ diarrea
□ hinchazón/comezón en la zona de la boca o la garganta

□ pérdida de conciencia
□ otro______________________
□ otro ______________________
□ otro_______________________

Autorización para dar información médica:

Por este documento autorizo a__________________________________ para dar información relativa a reacción anafiláctica/alérgica de
(Clínica/Proveedor)

mi hijo(a) ___________________________________ al personal de Servicios de salud estudiantil en ___________________________.
Nombre del estudiante Escuela

___________________________________ ____________________________________ ______________________
Firma de padres/custodio legal Nombre en letra de molde Fecha

Doy permiso para que la enfermera escolar contacte al doctor de mi hijo(a) con respecto a su reacción anafiláctica/alérgica y a su tratamiento

___________________________________ ____________________________________ _____________________
Firma de Padres/custodio legal Nombre en letra de molde Fecha

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ALLERGY/ANAPHYLAXIS PHYSICIAN ORDERS

Student Name:__________________ Date of Birth:__________ School Name: __________Teacher:__________

ALLERGY TO:____

Asthmatic € Yes € No

**Higher risk for severe reaction

◷ STEP 1: TREATMENT ◷

Symptoms:	**Give Checked Medication:** (** to be determined by physician authorizing treatment)	
€ If a food allergen has been ingested, but ***no symptoms***:	€ Epinephrine	€ Antihistamine
€ Mouth Itching, tingling, or swelling of lips, tongue, mouth	€ Epinephrine	€ Antihistamine
€ Skin Hives, itchy rash, swelling of the face or extremities	€ Epinephrine	€ Antihistamine
€ Gut Nausea, abdominal cramps, vomiting, diarrhea	€ Epinephrine	€ Antihistamine
€ Throat: Tightening of throat, hoarseness, hacking cough	€ Epinephrine	€ Antihistamine
€ Lung: Shortness of breath, repetitive coughing, wheezing	€ Epinephrine	€ Antihistamine
€ Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness	€ Epinephrine	€ Antihistamine
€ Other: ____	€ Epinephrine	€ Antihistamine
€ If reaction is progressing (several of the above areas affected), give:	€ Epinephrine	€ Antihistamine

Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give____

Medication/dose/route

Other: give____

Medication/dose/route

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

◷ STEP 2: EMERGENCY CALLS ◷

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. __________________________________ Phone Number: ____

3. Parent__________________________________ Phone Number(s) ______________________________________

4. Emergency contacts:

Name/Relationship Phone Number(s)

a. ____ 1.)________________________ 2.) ______________________

b. ____1.)________________________ 2.) ______________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Form in compliance with SB27

Parent/Guardian's Signature____ Date__________________________

Doctor's Signature____ Date__________________________

(Required)