Santa Fe Independent School District

Annual Health Services Prescription

Physician/Parent Authorization for Anaphylaxis Management

*This form is to be renewed at the beginning of each school year
For children with multiple severe allergies, use one form for each allergy.

ALLERGY TO: _____

Student name: _____ Grade: _____ DOB: _____

Parent name: _____ Phone (H): _____ (W) _____

Physician name: _____ Phone: _____ Hospital: _____

Asthmatic? Yes (High risk for severe reaction) ☐ No ☐

Systems	Possible Symptoms:
MOUTH	*itching & swelling of the lips, tongue, or mouth*
THROAT*	*itching and/or sense of tightness in the throat, hoarseness, & hacking cough*
SKIN	hives, itchy rash, &/or swelling about the face or extremities
ABDOMIN	nausea, abdominal cramps, vomiting, &/or diarrhea
LUNG*	*shortness of breath, repetitive coughing, &/or wheezing*
HEART*	*"thready" pulse, "passing-out"*

The severity of symptoms can quickly change. ***All above symptoms can potentially progress to a life-threatening situation.* Do not hesitate to call 9-1-1!**

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

Action Plan for Known/Suspected Sting (Bite)/Ingestion/Inhalation

ACTION FOR MINOR REACTION

Probable symptoms for this student include_____

1) Administer _____
medication/dose/route
2) Contact Parents or emergency contacts.

*If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

Probable symptoms include_____

1) **IMMEDIATELY!** Administer _____
medication/dose/route
2) Call 9-1-1 & tell them it is life-threatening.
3) Contact Parents or emergency contacts.
4) Contact Physician.

FOR SELF-ADMINISTRATION ONLY

Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself? Yes___ No____
Has this student been trained in the signs and symptoms of minor and major reactions? Yes ____ No____
Is this student capable of self-administering EpiPen®? Yes___ No___
Can this be safely self-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 EpiPen®? Yes___ No__

Physician's Signature: _____
Date :_____Physician's Name:_____
Phone:_____
Address:_____Fax_____

TO BE COMPLETED BY THE PARENT

I, the undersigned, parent/guardian of _____ request that an EpiPen® be administered to my child, as prescribed by the physician. 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 a standardized procedure 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/health care 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 EpiPen®. 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 a standardized procedure that has been approved by the physician.

Parent's Signature: _____ Date:_____

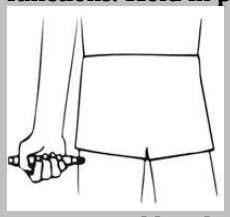
EMERGENCY CONTACTS

1. _____ Relation: _____ Daytime phone _____
2. _____ Relation: _____ Daytime phone _____
3. _____ Relation: _____ Daytime phone _____

FOR OFFICE USE ONLY

How to use an EpiPen® and EpiPen® Jr

1. **Pull off gray safety cap**
2. **Place black tip on outer thigh (always apply to thigh)**
3. **Using a swing and jab motion, press hard into thigh until auto-injector mechanism functions. Hold in place and count to 10.**

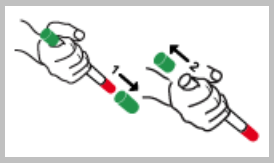


4. **Remove and bend needle back on hard surface. Place back in plastic tube and send EpiPen® with patient to hospital.**

MEMBERS-EPIPEN/TWINJECT

1. _____
2. _____
3. _____

How to use Twinject® 0.3 mg and 0.15 mg injector

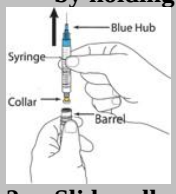


1. **Remove end caps labeled "1" and "2".**
2. **Put rounded tip against outer thigh, press down firmly until needle penetrates. Hold in place and count to 10, then remove.**

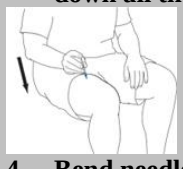
<u>SECOND DOSE ADMINISTRATION:</u>

If symptoms don't improve within 10 minutes, administer second dose:

1. **Unscrew rounded tip and pull syringe from barrel by holding blue collar at needle base.**



2. **Slide yellow collar off plunger.**
3. **Put needle into thigh through skin, push plunger down all the way and remove.**



4. **Bend needle back on hard surface. Send Twinject® with patient to hospital.**