Crandall Independent School District

Annual Health Services Prescription

Physician/Parent Authorization for Allergy/ 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 trained and 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___

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