Humble Independent School District Health Services

Physician's Documentation

ALLERGY

Student Name: ______________________________ **DOB:** ______________________________

ID#: ____________________ Grade: ____________________ Teacher: ______________________________

Parent/Guardian Name: ____

Best Contact #: ______________________________ Alternate Contact #: ____________________

ALLERGENS WHICH CAUSE SEVERE REACTION

☐ NUTS: TYPE? ____________________

☐ Ingestion ☐ Touch Smell Airborne

☐ OTHER FOODS: TYPE? ____________________

☐ Ingestion ☐ Touch Smell Airborne

☐ INSECT: TYPE? ____________________

☐ LATEX: ____________________

PREVIOUS REACTION: Yes ________ No ________

Describe Previous Reactions____________________

Emergency Actions are necessary when the student has the following symptoms:

☐ HIVES

☐ ITCHING

☐ SWELLING

☐ DIFFICULTY BREATHING

☐ CYANOSIS

☐ OTHER ____________________

SCHOOL ACTION PLAN:

NOTE: Administration of Medication form must also be competed in addition to this form

Steps to take during an allergic reaction:

☐ **For the following symptoms ______________________________give the following:**

Medication name:______________________________Dose:______________________________

☐ **For the following symptoms ______________________________give the following:**

Medication name:______________________________Dose:______________________________

☐ **CALL 911**

Comments/Special Instructions: ____

____

State law allows a student to carry an epinephrine device if the following criteria are followed.
The parent of the student provides to the school:

a. Written authorization for the student to self-administer the prescription medicine while on school property or at a school-related event or activity; and
b. A written statement, signed by the student's physician or other licensed health care provider that states:
    - That the student has asthma or anaphylaxis and is capable of self-administering the medicine;
    - The name and purpose of the medicine;
    - The prescribed dosage for the medicine;
    - The times at which or circumstances under which the medicine may be administered; and
    - The period for which the medicine is prescribed. The physician's statement must be kept on file with the school nurse

Physician initials in box indicate the following:

☐ I have instructed the above named student in the proper use of his/her epinephrine device.
It is my professional opinion that he/she should be **allowed to carry and self-administer the epinephrine device** as needed. The student will then be accompanied to the clinic for evaluation and follow-up care.

Physician Name____________________ **Physician Signature**____________________ **Date**__________

Parent Name____________________ Parent Signature____________________ Date__________

School Nurse Signature______________________________ Date ____________________

Humble Independent School District Health Services

Authorization for Release of Medical Records

Student____ DOB______________ Date_______________

Campus____ Grade_____________

I grant permission for the release of medical information and physician recommendations as it pertains to the student's accommodations which will allow for participation in the educational process with minimal disruption.

Information requested____

____

____

From: (Physician Name & Address)

____

____

____

____

To: (School Nurse)

____

____

____

____

____

Signature of Parent/Guardian,
(Student if 18 years or older)

____

Date

The mission of Humble ISD Health Services is to enhance the health and well being of the students, staff, and community thus supporting the education of all students through maximizing their educational time.

Humble Independent School District Health Services

Allergy Health History

Student Name:____

Student ID:______________________________________ Date of Birth: ____________________

Parent/Guardian:__________________________________ Home Phone:____________________

Cell Phone:______________________________________ Work Phone:____________________

1. Does your child have a diagnosis of an allergy from a healthcare provider: ☐ **No** ☐ **Yes**

Allergist:______________________________ Phone:______________________________

2. History of Current Status:

a. What is your child allergic to:

☐ Peanuts
☐ Eggs
☐ Milk
☐ Latex
☐ Soy
☐ Tree Nuts ______________
☐ Fish/Shellfish
☐ Chemicals______________
☐ Vapors ______________
☐ Insects ______________
☐ Other: ______________________________

b. Age of student when allergy first discovered:__________

c. How many times has the student had a reaction:
☐ Never ☐ Once ☐ More than once

d. Explain their past reaction(s):______________________________
____
____

e. Symptoms:______________________________
____

f. Are the food allergy reactions: ☐Same ☐Better ☐Worse

3. Trigger and Symptoms:

a. What are the early signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say) ______________________________

b. How does your child communicate his/her symptoms? ______________________________

c. How quickly do symptoms appear after exposure? Within: _____ secs _____ mins _____ hrs _____ days

d. Please check the symptoms your child has experienced in the past:

Skin	Mouth	Abdominal	Throat	Lungs	Heart
☐ Hives	☐ Itching	☐ Nausea	☐ Itching	☐ Shortness of breath	☐ Weak pulse
☐ Itching	☐ Swelling (lips, tongue, mouth)	☐ Cramps	☐ Tightness	☐ Repetitive Cough	☐ Loss of Consciousness
☐ Rash		☐ Vomiting	☐ Hoarseness	☐ Wheezing	
☐ Flushing		☐ Diarrhea	☐ Cough		
☐ Swelling (face, arms, hands, legs)					

4. Treatment:

a) How have past reactions been treated?_

b) How effective was the student's response to treatment? _______

c) Was there an emergency room visit? ☐ No ☐ Yes, explain:___

d) Was the student admitted to the hospital? ☐ No ☐ Yes, explain:_____

e) What treatment or medication has your healthcare provider recommended for use in an allergic reaction?_

____

f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: ______________

____

5. Self Care:

a. Is your student able to monitor and prevent their own exposure? ☐ No ☐ Yes

b. Does your student:

1. Know what foods to avoid………………………….............................. ☐ No ☐ Yes
2. Ask about food ingredients………………………………………........... ☐ No ☐ Yes
3. Read and understand food labels…………………………………........... ☐ No ☐ Yes
4. Tell an adult immediately after an exposure………………………………. ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace, watchband………………………. ☐ No ☐ Yes
6. Tell peers and adults about the allergy………………………………………. ☐ No ☐ Yes
7. Firmly refuse a problem food…………………………………………….. ☐ No ☐ Yes

c. Does you student know how to use their emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family/Home

a. How do you feel that the whole family is coping with your student's food allergy?

b. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

c. Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her food allergy? ☐ No ☐ Yes

7. General Health:

a. How is your child's general health other than having a food allergy? ___________________________

b. Does your child have other health conditions? ____

c. Hospitalizations? ____

d. Does your child have a history of asthma? _____ If yes, does he/she have an Asthma Action Plan? _____

e. Please add anything else you would like the school to know about your child's health: ______________________

____

8. Notes:

Parent/Guardian Signature:____ **Date:** ______________________

Reviewed by:_________________________________ **Campus:**________________ **Date:** ______________________

Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name____ **DOB**__________________
Last **First** **MI**

PARENT/GUARDIAN SECTION

______________ __ ____ _________________ _
Medication name **Strength** **Dosage** **Route** **Time**

Start Date____________________ Allergies____

Special Instructions/Duration____

Condition for which drug is to be given____

Medications currently taken at home____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

______________ __ ____ _________________ _
Medication name **Strength** **Dosage** **Route** **Time**

Start Date____________________ Allergies____

Special Instructions/Duration____

Condition for which drug is to be given____

Medications currently taken at home____

Physician's name (print)____________________ **Physician's signature**______________________

Phone number_________________ **Fax number**__________________ **Date**_________________

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature ____________________________ **Date**___________
Daytime Phone______________________________ Alternate phone ________________________