



Humble Independent School District Health Services

Physicians 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 Air Borne

OTHER FOODS: TYPE? _____

Ingestion Touch Smell Air Borne

INSECT: TYPE? _____

LATEX: _____

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

- HIVES
- ITCHING
- SWELLING
- DIFFICULTY BREATHING
- CYANOSIS
- OTHER _____

PREVIOUS REACTION: Yes _____ No _____

Describe Previous Reactions _____

SCHOOL ACTION PLAN:

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

Steps to take during an allergic reaction:

For symptoms of _____ give the following:
Medication name: _____ Dose: _____

For symptoms of _____ 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 _____