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 _____