

**YSLETA INDEPENDENT SCHOOL DISTRICT  
STUDENT HEALTH SERVICES  
PRACTITIONER'S WRITTEN ORDER/ALLERGY/ANAPHYLAXIS PLAN**

If medication and/or a health care procedure is to be administered during regular school hours for illness or disability, it is necessary for the District to receive the following:

1. A Practitioner's Written Order statement dated for the CURRENT school year signed by the parent, legal guardian or other person(s) having legal authority of the student AND the attending practitioner licensed to practice medicine in the state of Texas.
2. Original container with prescription label from a registered pharmacist licensed to practice in the state of Texas with current date, student's name, dose to be given, time(s) to be given, and medication route to be given.
3. The student is not allowed to carry his/her own medication or to self-administer the medication unless ordered by the licensed practitioner.
4. ONLY medications and/or health care procedures prescribed in writing by the attending practitioner licensed to practice medicine in the state of Texas are to be administered. The following will not be administered by any school personnel: Medication prescribed and/or purchased in foreign countries, herbal, alternative, or non-traditional preparations.

**All Nurses wherever employed must observe the law that requires them to have a written practitioner's order before the administration of any medication**

**AT THE END OF THE SCHOOL YEAR, ALL UNCLAIMED MEDICATION WILL BE DESTROYED ON THE LAST DAY OF SCHOOL.**

**COMPLETE AND RETURN THIS FORM TO THE SCHOOL NURSE**

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_ I.D.# \_\_\_\_\_ Grade \_\_\_\_\_  
 School Year 20 \_\_\_\_\_ -20 \_\_\_\_\_ School Name \_\_\_\_\_

**I. TO BE COMPLETED BY A LICENSED PRACTITIONER**

Allergic to: \_\_\_\_\_

Asthmatic:  Yes  No (Yes: higher risk for severe reaction)      Hereditary Angioedema:  Yes  No

**If allergen has been ingested or suspect ingestion/exposure:**

Symptoms		Give Checked Medication (Completed by Physician)	
	If food allergen has been ingested but no symptoms	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Mouth</b>	<input type="checkbox"/> itching, tingling sensation, swelling of lips, tongue, mouth, or drooling	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Throat</b>	<input type="checkbox"/> swelling of tongue and throat, difficulty swallowing, itching, tightness/closure, hoarseness, changes in voice	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Skin</b>	<input type="checkbox"/> hives, itchy rash, redness, swelling	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Gut</b>	<input type="checkbox"/> nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Lungs</b>	<input type="checkbox"/> respiratory difficulty, shortness of breath, cough, wheezing, stridor	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<b>Heart</b>	<input type="checkbox"/> weak or thready pulse, low blood pressure, dizziness, pale, loss of consciousness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
	<input type="checkbox"/> Other:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
	<input type="checkbox"/> If reaction is progressing (several of the above area affected) give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

**Dosage** (Check all that apply)

**Epinephrine** Inject intramuscularly-Epinephrine injection, auto-injector:  0.3 mg    Epinephrine Jr. auto-injector:  0.15 mg

**Antihistamine** \_\_\_\_\_  
 Medication/Dose/Route

**Other** \_\_\_\_\_  
 Medication/Dose/Route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis**

I understand that the emergency medication listed above may be administered by a trained unlicensed staff member and that 911 will be called whenever the above emergency medication is given. In addition, for my patient I would like to add the following \_\_\_\_\_.

Yes  No    The above-named student is capable of self-administration and should carry his/her own medication.

\_\_\_\_\_  
 Printed Name of Practitioner                      Practitioner's Signature                      Telephone Number                      Date

FAX

## **II. PARENT/GUARDIAN SECTION**

**Parent/Guardian Authorization and Responsibility:** I, the undersigned, parent/guardian of the above-named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider for my child in accordance with state laws and regulations. I understand medication may only be administered by licensed health professionals, and trained unlicensed personnel, according to state laws and regulations. I also understand that prescribed emergency medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task and 911 will be called immediately following the administration of any emergency medication.

**Texas Education Code 22.052** states that district employees are immune from civil liability from damages or injuries resulting from the administration of medication to a student if: (1) the school district has received a written request to administer the medication from the parent, legal guardian, or other person having legal control of the student; and (2) when administering prescription medication, the medication is administered from a container that appears to be the original container and properly labeled.

I agree to:

1. Notify the school nurse if any emergency medication was administered to my child within 12 hours of attending school.
2. Notify the school nurse if there are any changes in my child's medical condition and/or treatment plan.
4. Maintain current phone numbers with the school nurse and school office in case 911 is called.
5. Provide the necessary medication, supplies, and equipment for my child's treatment while at school.

### **Parent /Guardian Authorization for School Staff to Communicate Health Information**

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my child's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, and medical treatments. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate.

**Parent/Guardian initials** I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's Allergy and authorized medication when necessary.

**Yes**  **No** I give permission for my child to carry his/her epinephrine pen, in accordance with the physician's instructions above.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **II. SECCION DE PADRE O TUTOR**

**Responsabilidad de Padre/Tutor:** Yo, el abajo firmante, padre o tutor del estudiante nombrado arriba, solicita que sea realizado todos los procedimientos y la administración de medicamento según lo autorizado por el proveedor de salud de mi hijo de acuerdo con las leyes y reglamentos estatales. Entiendo que el medicamento sólo puede ser administrado por profesionales de salud licenciados y personal sin licencia que ha sido entrenado conforme a las leyes y reglas estatales. También entiendo que el medicamento prescrito de emergencia solo se puede administrar a mi hijo/a por una enfermera escolar o por mí hasta que personal de la escuela complete el entrenamiento requerido por el Distrito. En ausencia de una persona con licencia médica como una enfermera escolar, sólo el personal capacitado estará autorizado a realizar esta tarea y 911 será llamado inmediatamente después de administración de cualquier medicamento de emergencia.

**El Código 22.052 de la Educación de Texas** afirma que los empleados del Distrito son inmunes a la responsabilidad civil de daños o lesiones derivados por la administración de medicamento al estudiante si: (1) el Distrito Escolar ha recibido una solicitud por escrito para administrar el medicamento firmado por el Padre o Tutor legal del estudiante; y (2) cuando administrando el medicamento prescrito, el medicamento parece venir del envase original y tiene la etiqueta correcta de la farmacia.

Estoy de acuerdo en:

1. Notificar a la enfermera si el medicamento de emergencia fue administrado a mi hijo dentro de 12 horas de asistir a la escuela.
2. Notificar a la enfermera si hay algún cambio en la condición medica de mi hijo y/o el plan de tratamiento.
3. Mantener los números de teléfono actuales con la enfermera o la oficina escolar en caso de que se llama al 911.
4. Proporcionar el medicamento, suministros y equipos necesarios para el tratamiento de mi hijo/a en la escuela.

### **Autorización del padre de familia/tutor para que el Personal Escolar Comuniquen los Datos Médicos**

Autorizo a los representantes del Distrito, incluyendo los profesionales médicos y UAPs del Distrito, a compartir con el profesional médico o proveedor de salud mencionado en la parte superior a obtener datos médicos de mi hijo/a al fin de planificar, implementar o aclarar las acciones necesarias en la administración de servicios escolares relacionados con la salud, que incluyen pero no se limitan a: atención de urgencia, cuidado para cualquier diagnóstico, o tratamientos médicos. Al firmar esta Autorización reconozco que la información usada o divulgada referente a los Datos Médicos personales e Identificables de mi hijo/a puede ser sujeto a re-divulgación por el personal autorizado y a las personas con los que se comuniquen.

**Iniciales del Padre/Tutor**

**Si**  **No** Doy permiso para que mi hijo/a cargue su pluma de epinefrina, de acuerdo con las instrucciones del médico delineadas arriba.

**Firma del Padre/Tutor:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_