



EL PASO COUNTY SCHOOL 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. (Exception: U.S. Military)
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)

If allergen has been ingested or suspect ingestion/exposure:

Table with 4 columns: Symptoms, Give Checked Medication, Physician authorized treatment. Rows include No symptoms, Mouth, Throat, Skin, Gut, Lungs, Heart, and Other.

Dosage

Epinephrine Inject intramuscularly (circle appropriate dose) Epinephrine injection, auto-injector: 0.3 mg / 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.

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.

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:** _____

EMERGENCY CONTACT PERSON: _____ **PHONE NUMBER:** _____

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.

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.

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:** _____

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Copy given to Cafeteria Manager

Signature – Cafeteria Manager _____ **Date:** _____