BASTROP ISD

ANAPHYLAXIS TREATMENT PLAN AND PHYSICIAN'S ORDER FORM

Student Name: _____				**DOB:** _____
STUDENT ALLERGY HISTORY:				
1. Has this student had an anaphylactic reaction? ☐ Yes ☐ No				
2. What is this student allergic to?	☐ Dairy	☐ Peanuts	☐ Soy	☐ Other:_____
	☐ Eggs	☐ Sesame	☐ Sting	☐ Other:_____
	☐ Fin Fish	☐ Shellfish	☐ Tree Nuts	☐ Other:_____
3. Has this student ever been allergy tested? ☐ Yes ☐ No **If yes, date tested:** _____				
4. Has the student and family been educated about the avoidance of the offending agent? ☐ Yes ☐ No				
5. Has the student and family been educated in the indications for EpiPen/EpiPen Jr administration, checking outdated medicine, and storing the EpiPen/EpiPen Jr? ☐ Yes ☐ No				
6. If insect bite, has this student had venom testing? ☐ Yes ☐ No **Has this student been desensitized to the venom?** ☐ Yes ☐ No				
7. Does this student have a medical alert bracelet? ☐ Yes ☐ No				
8. Does this student have asthma? ☐ Yes ☐ No				
9. Is this student able to safely self-administer the EpiPen/EpiPen Jr? ☐ Yes ☐ No				

SCHOOL DISTRICT EPIPEN PROTOCOL:

B.I.S.D. policy states it '…allows some medications to be carried and administered by students, rather than school staff. The three medical problems that students may self-administer are rescue inhalers for asthma, medication for severe allergic reactions, and all medication and supplies associated with diabetes management. The student is responsible to keep the school nurse informed when he/she administers the medication. Parent/guardians must still submit written permission for the self-administration of these medications on a yearly basis. An MD order must state that the student has the associated condition that the medication is prescribed for and is capable of self-administering the medication/medical regimen, along with directions for the administration of the medication/medical regimen and the duration of time that the medication/regimen will be used. EMS will be notified ANY time medication for severe allergic reaction is administered.'

Student dose (check one):	☐ EpiPen Jr 0.15mg
	☐ EpiPen 0.30 mg
	☐ Other _____
Do you agree with the above treatment plan? ☐ Yes ☐ No	
Date: _____	**Prescriber's Signature:** _____
Printed Name: _____ **Phone:** _____	

PARENTAL CONSENT:

The above named student has my permission to self-administer prescription anaphylaxis medication while on school property or at a school-related event or activity.

Date: _____	**Parent/guardian Signature:** _____
Printed Name: _____	**Relationship:** _____

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