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Exhibit A—Request for Administration of Medication at School

Date school received form: _____

Student's name *(print)*: _____

Date of birth: _____

Grade: _____

Teacher/Classroom: _____

Name of medication: _____

Type of medication

☐ Prescription

☐ Non-prescription

Reason for medication: _____

Form of medication/treatment

(Check appropriate box)

☐ Tablet/capsule

☐ Liquid

☐ Inhalant

☐ Injection

☐ Nebulizer

☐ Spray/Cream or lotion (e.g., insect repellant)

☐ Other: _____

Instructions
(Schedule and dose to be given at school)

Start:

☐ Date that school received form: _____

☐ Other date: _____

Stop:

☐ End of school year

☐ Other date: _____

Restrictions and/or important side effects

☐ None anticipated

☐ Yes
If yes, describe: _____

Special storage instructions

☐ None

☐ Refrigerate

☐ Other *(please describe)*: _____

Physician information

Name *(print)*: _____

Address: _____

Phone number: _____

Physician's signature: _____

Date: _____

To be completed by the parent or guardian

I give permission for _____ *(student's name)* to receive the above medication at school in accordance with District policy. [See FFAC]

Parent's or guardian's signature: _____

Date: _____

This form was developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services.

Exhibit B—Authorization to Secure Emergency Medical Treatment of a Student

Student's name *(print)*: _____

Date of birth: _____

Grade: _____

Name of parent or guardian: _____

Address: _____

Work phone number: _____

Home phone number: _____

Mobile phone number: _____

Local person to contact if parent or guardian cannot be reached

Name: _____

Phone number: _____

Relationship to student: _____

Student's physician or other preferred health-care provider

Name: _____

Phone number: _____

Student's dentist

Name: _____

Phone number: _____

Medications or drugs to which the student has had an allergic or adverse reaction:

_____

Part 1

I hereby authorize the Superintendent of San Felipe Del Rio CISD, or a designated representative to secure any and all emergency medical care and treatment for _____ *(student's name)* for acute illness suffered, injury sustained, or other situation requiring emergency medical treatment while at school or participating in school-related activities. I prefer that emergency treatment be secured at

_____ *(name of preferred medical facility)*. The District may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions:

_____.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

(Check one)

☐ **I do** have medical insurance coverage on my child with:

_____

☐ **I do not** have medical insurance coverage on my child.

Parent's or guardian's signature: _____

Date: _____

Part 2

This is to certify that I authorize the Superintendent of _____ School District or a designated representative to provide and administer to _____ *(student's name)*:

(Check all that apply)

☐ Tylenol (or generic acetaminophen) if he or she has a temperature of 101 or higher;

☐ Benadryl (or generic antihistamine) if he or she experiences a local or systemic allergic reaction such as hives, welts, severe swelling, generalized itching, or tingling of the mouth or throat; or

☐ Other: _____ ***[List other medications specific to another emergency situation as determined by the District's medical adviser.]***

I understand that the District will attempt to contact me as soon as possible if such action is necessary.

Parent's or guardian's signature: _____

Date: _____

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.

Exhibit C—Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication

Note: For information addressing students at risk for anaphylaxis, see FFAF.

Student's name *(print)*: _____

Date of birth: _____

Grade: _____

Name or parent or guardian: _____

Address: _____

Work phone number: _____

Home phone number: _____

Mobile phone number: _____

Prescribing physician or health-care provider

Name: _____

Phone number: _____

Description of condition/reason for medication:

_____

Prescribed medication and dosage: _____

How/when the medication should be used at school *(dosage, method, and times)*:

_____

Anticipated length of treatment: _____

Possible adverse reaction: _____

_____ *(student's name)* has asthma and/or anaphylaxis and is treated with prescription medication. He or she is capable of administering his or her own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

Parent's or guardian's signature: _____

Date: _____

Signature of health-care provider: _____

Date: _____

Exhibit D—Notice to Parent or Guardian for Emergency Administration of Unassigned Epinephrine Auto-Injectors

Note to administrator: This notice must be sent to each parent or guardian before a policy authorizing trained individuals to administer District-provided, unassigned epinephrine auto-injectors is implemented by the District, and before the start of each school year. Coordinate this notice with Board policy. [See FFAC(LOCAL)]

_____ *(date)*

Dear parent or guardian:

In accordance with Chapter 38, Subchapter E of the Education Code, the Board of San Felipe Del Rio Consolidated Independent School District has adopted a policy to allow authorized school personnel who have been adequately trained to administer an unassigned epinephrine auto-injector to a person who is reasonably believed to be experiencing an anaphylactic reaction.

Authorized and trained individuals may administer an epinephrine auto-injector at any time to a person experiencing anaphylaxis on a school campus.

The District will ensure that at each campus a sufficient number of school personnel and volunteers are trained to administer epinephrine so that at least one trained individual is present on campus during regular school hours and whenever school personnel are physically on site for school-sponsored activities.

Authorized and trained individuals may administer an unassigned epinephrine auto-injector to a person experiencing anaphylaxis at an off-campus school event or while in transit to or from a school event when an unassigned epinephrine auto-injector is available.

If you have any questions regarding this notice, please feel free to call Jorge L. Garza, Ed. D., District epinephrine coordinator, at (830) 778-4170.

Sincerely,

Carlos H. Rios, Ed. D.

Superintendent of Schools

Exhibit E—Training Documentation on Emergency Administration of Epinephrine Auto-Injectors

In accordance with state law, I have received the following required annual training:

Type of training

(Check all that apply)

☐ Formal/in-person training

☐ Online training

Initial or refresher training

☐ Initial training, including hands-on training with an epinephrine auto-injector trainer

☐ Annual refresher training, including hands-on demonstration of administration skills

Subjects covered in training

☐ Recognizing the signs and symptoms of anaphylaxis;

☐ Administering an epinephrine auto-injector;

☐ Implementing emergency procedures, including prompt notification of local emergency medical services;

☐ Notifying parents or legal guardians, and other authorities after administering an epinephrine auto-injector;

☐ Properly inspecting epinephrine auto-injectors for usage and expiration; and

☐ Properly disposing of used or expired epinephrine auto-injectors.

Name of person trained *(print)*: _____

Position/title: _____

Date of training: _____

Number of hours trained: _____

Name of person/entity that provided training: _____

Signature of person trained: _____

Signature of trainer *(in-person training only)*: _____

(If training was taken online, please attach a certificate of training completion.)

Return the completed form to Jorge L. Garza Ed. D., District epinephrine coordinator. [See FFAC(REGULATION)]

Exhibit F—Agreement to Administer Unassigned Epinephrine Auto-Injector

Note: In accordance with Section 37.606(c) of the Texas Administration Code, trained school personnel or school volunteers who administer an unassigned epinephrine auto-injector must submit a signed statement indicating that they agree to perform the service of administering an unassigned epinephrine auto-injector to a student or individual who may be experiencing anaphylaxis.

In accordance with state law, I agree to perform the service of administering an unassigned epinephrine auto-injector to a student or individual who may be experiencing anaphylaxis.

I understand that I must also submit documentation of training on emergency administration of epinephrine auto-injectors.

Name of person *(print)*: _____

Position/title: _____

Date: _____

Exhibit G—Epinephrine Auto-Injector Administration Reporting Form

Note: In accordance with Section 38.209 of the Texas Education Code, the school campus will report the following information to the District office, the physician or other person who prescribed the epinephrine auto-injector, the commissioner of education, and the commissioner of state health services, not later than the tenth business day after the date school personnel or a school volunteer administers an epinephrine auto-injector.

This form is designed to report the use of an epinephrine auto-injector to the District office, the physician or other person who prescribed the unassigned epinephrine auto-injector, and the commissioner of education.

The Texas Department of State Health Services (DSHS) form[i] can be completed and submitted electronically to meet the requirements of reporting to the commissioner of state health services.

In addition, the District requires a person who administers an epinephrine auto-injector to meet with the District's epinephrine coordinator within five days of administration to document needed information for the DSHS electronic submission form.

Recipient information

Person who received the unassigned epinephrine auto-injector injection:

(Check one)

☐ Student
☐ School personnel or school volunteer
☐ Visitor

Age of person who received the unassigned epinephrine auto-injector injection: _____

Location and dosage information

Physical location of where the injection was administered *(examples: cafeteria, football field, school bus, and the like)*:

_____

Number of doses administered: *(one dose = one epinephrine auto-injector)*: _____

Type of dosage administered:

☐ Child dose
☐ Adult dose

Other information

Date administered: _____

Title of the person who administered the injection *(example: teacher, librarian, basketball coach, school volunteer, and the like)*:

_____

Did the person who received the epinephrine auto-injector injection have a known history of anaphylaxis or allergies requiring epinephrine auto-injectors?

- ☐ Yes
- ☐ No
- ☐ Unknown

Was the school's unassigned epinephrine auto-injector utilized?

- ☐ Yes
- ☐ No

Was the individual who received the epinephrine auto-injector injection transported to local emergency medical services?

- ☐ Yes
- ☐ No

Symptom information

Respiratory

- ☐ Wheezing or coughing
- ☐ Trouble breathing or shortness of breath
- ☐ Tightness in throat or chest
- ☐ Tingling or numbing sensation
- ☐ N/A (no respiratory symptoms)

Skin

- ☐ Rash
- ☐ Hives
- ☐ Itchiness
- ☐ N/A (no skin symptoms)

Gastrointestinal

- ☐ Cramps
- ☐ Diarrhea
- ☐ Vomiting
- ☐ N/A (no gastrointestinal symptoms)

Central nervous system

- ☐ Headache
- ☐ Swelling of lips, tongue, or throat
- ☐ Loss of consciousness
- ☐ Anxiety
- ☐ N/A (no central nervous system symptoms)

Cardiovascular system

- ☐ Dizziness or lightheadedness
- ☐ Rapid pulse
- ☐ Low blood pressure
- ☐ N/A (no cardiovascular symptoms)

Other

- ☐ Please list signs or symptoms not listed above, if applicable:

_____

Suspected cause

Please indicate the suspected cause or trigger of the anaphylaxis:

- ☐ Food
- ☐ Latex
- ☐ Insect sting or bite
- ☐ Medication
- ☐ Unknown
- ☐ Other

If “Other,” please explain:

_____

_____

[i] Electronic Submission Form for Required Reporting of Administered Epinephrine Auto-Injectors to DSHS: https://www.dshs.texas.gov/schoolhealth/forms/ReportingForm-Epinephrine.aspx

Exhibit H—Inventory: Unassigned Epinephrine Auto-Injectors

Note: Each campus will check the inventory of unassigned epinephrine auto-injectors monthly for expiration and replacement in accordance with the District's administrative regulations and indicate the physical and secure location of each unassigned epinephrine auto-injector under the campus' control.

Campus Name: _____ Date: _____

All San Felipe Del Rio CISD campuses are required to check the inventory and expiration dates for epinephrine auto-injectors every month. Return the completed form to Jorge L. Garza Ed. D., District epinephrine coordinator. [See FFAC(REGULATION)]

Inventory Verified ***(date and initial)***	**General Location** ***(on campus, off campus school event, transportation)***	**Prescription Number**	**Secure Location**	**Expiration Date**	**Date Used**	**Date Disposed**

I affirm the information contained in this report is accurate.

Name of person (print): _____

Position/title: _____

Date: _____