

**MORRIS HILLS REGIONAL DISTRICT
EMERGENCY HEALTH CARE PLAN
FOR ALLERGIC REACTIONS**

*Attach Photo
of child here*

This form must be completed by your child's physician/advanced practice nurse and then signed by the parent/guardian/student. (For students with Asthma medication, please use the Asthma Action form.)

Student Name _____ DOB _____

SECTION I: TO BE COMPLETED BY PHYSICIAN/ADVANCED PRACTICE NURSE

A.

Allergy To _____

Asthmatic Yes* No *Higher risk for severe reaction

Has student received epinephrine for anaphylaxis (date) _____ ___yes ___no
 Has the student been tested? _____yes ___no
 Has student undergone insect sting desensitization? _____yes ___no
 Is student able to participate fully in all school athletic programs? _____yes ___no
 Does student have medic alert bracelet? _____yes ___no

Symptoms:	Give Checked Medication	
• If a food allergen has been ingested, but no symptoms:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Throat Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Lung Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Heart Weak or thready pulse, low BP, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Other _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

All above symptoms can potentially progress to a life-threatening situation!

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen JR EpiPen Twinject 0.3mg Twinject 0.15mg

Epinephrine may be repeated in _____ minutes.

Antihistamine: (given concomitant/Epinephrine) _____

Other: give (medication, dose, route) _____

Emergency Contacts:

Name/Relationship	Phone Numbers	
1. _____	1.) _____	2.) _____
2. _____	1.) _____	2.) _____
3. _____	1.) _____	2.) _____

B. Treatment by Delegate When Nurse Not Present – NJ State Assembly Act Senate No. 79 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine only to a pupil for anaphylaxis when the nurse is not physically present at the scene; field trips, before and after school sponsored activities.

1. ___ Delegate Order – For suspected exposure to allergen(s) listed above, delegates are to immediately administer epinephrine (circle one):

EpiPen Jr EpiPen 0.3mg Twinject 0.3mg (auto injector only) Twinject 0.15mg (auto injector only)

2. ___ This student’s order should not be delegated.

C. Treatment by Student (Self-Administration) – NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for potentially life-threatening allergic reaction provided proper procedures are followed.

May student self-administer the medication prescribed (epinephrine with other prescribed medications)? ___yes
___no

(If yes, please complete the questions below. In order to have permission to self-administer, all questions in C must be checked “yes”.)

___yes ___no Student understands the purpose, proper technique of administration and frequency of use of the medication prescribed above and is capable of self-administration of the medication.

___yes ___no Student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used medication.

D. Emergency Procedure

1. Administer epinephrine via auto injector mechanism
2. Call 911 and state that a student has an allergic/anaphylactic reaction and request that paramedics transport the student to the nearest hospital.
3. Notify parents/guardians.

Physician Signature _____ **Date:** _____

Stamp or name, address and phone printed:

SECTION II – TO BE COMPLETED BY PARENT/GUARDIAN

A. Parent Authorization (to be completed for all students) –

I hereby give permission for my child to receive emergency epinephrine medication at school as prescribed above. I also give permission for the release and exchange of information between the school nurses and my child’s health care provider concerning my child’s health and medication. In addition, I understand that this information will be shared with school staff on a need to know basis.

Date Parent Signature

B. Parent authorization not to delegate: If you choose not to have a delegate for your child there may not be a nurse available to administer emergency epinephrine if necessary.

I do not give consent for a delegate to be assigned to my child.

Date Parent Signature

C. Parent authorization for the administration of epinephrine by designees/delegates:

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates trained by the certified school nurse to administer epinephrine in the event that the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to a student via a pre-filled auto-injector mechanism.

Date Parent Signature

D. Parent Authorization (for students with physician permission to self-administer medication) -

1. I understand that the district and its employees or agent shall incur not liability as a result of any injury arising from the self-administration by the student of the medication prescribed on this form and that I indemnify and hold harmless the district and its employees or agent against any claims arising out of the self-administration of medication by the student.

Date Parent Signature

2. I give permission for my child to self-administer medication as prescribed on the form for the current school year as I consider him/her to be responsible and capable of self-administration of medication. Medication must be kept in its original prescription container. I understand my child is to keep the medication for self-administration with him/her at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre-measured dose of antihistamine, in its original labeled container, is to be kept with the student, along with epinephrine, at all times. Extra medication will be sent to school to be kept in the Health Office.

Date Parent Signature

E. Parent Agreement to Notify School

I will notify the school at least 24hrs in advance if my child is going to attend a school sponsored event. In the event this does not occur I understand that a delegate may not be present to administer emergency epinephrine if necessary.

Date Parent Signature

SECTION 111 – TO BE COMPLETED BY STUDENT

A. Student Agreement for Self-Administration –

I understand and I will use this medication as directed by my physician. I will be responsible in carrying and using this medication as described while in school, on field trips and at school sponsored events. I have been instructed on how to self-administer this medication and understand the side effects of improper use.

Date

Student Signature

Parent Signature

B. Student Agreement for Delegate (Grades six through twelve)

I understand that I will be assigned a delegate at school sponsored events.

Date

Student Signature

Parent Signature