Photo of Student Here

Chester School District
50 North Road
Chester, NJ 07930

EMERGENCY MEDICAL PLAN FOR ALLERGIC REACTIONS

This form is for students with allergies and 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 _____Teacher/HR _____

SECTION 1 – TO BE COMPLETED BY PHYSICIAN/ADVANCED PRACTICE NURSE

Allergen _____ Reactions in past _____

Is this a potentially life-threatening allergic reaction?	____yes	____no
Is this student asthmatic? (with a higher risk for severe reactions)	____yes	____no
Has allergy testing been recommended?	____yes	____no
Does student require seating at an allergen safe cafeteria table?	____yes	____no

Step 1A – Treatment by Nurse When Present

Symptoms	**Give Checked Medication**
If a food has been ingested (or student stung by insect if order is for insect sting allergy)_**but *no symptoms***:	___Epinephrine ___Antihistamine
Mouth (itching, tingling or swelling of lips, tongue, mouth)	___Epinephrine___Antihistamine
Skin (hives, itchy rash, swelling of face or extremities)	___Epinephrine ___Antihistamine
Gut (nausea, tightening of throat, hoarseness, hacking cough)	___Epinephrine ___Antihistamine
Throat (Tightening of throat, hoarseness, hacking cough)	___Epinephrine ___Antihistamine
Lung (Shortness of breath, repetitive coughing, wheezing)	___Epinephrine ___Antihistamine
Heart (thready pulse, low BP, fainting, pale, blueness)	___Epinephrine __Antihistamine
If reaction is progressing (several of the above areas affected)	___Epinephrine __Antihistamine
Other:	___Epinephrine __Antihistamine

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

Epinephrine may be repeated in _____minutes.

Antihistamine: give (medication, dose, route) _____

Other: give (medication, dose, route) _____

Step 1B – Treatment by Delegate When Nurse Is 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 a one time dose of epinephrine** to a pupil for anaphylaxis when the nurse is not physically present at the scene.
(Check and complete either 1B1. or 1B2.)

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

EpiPen Jr EpiPen 3.0mg Twinject 0.3mg (**auto injector only**) Twinject 0.15mg (**auto injector only**)

2. _____This student's order should not be delegated. Physician's Signature _____

Step 1C – Treatment by Student (Self-Administration) – NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction provided proper procedures are followed**.**

May student self-administer the medication prescribed (epinephrine and antihistamine)?___Yes__No
(If yes, please complete the questions below. In order to have permission to self-administer, all questions in Step 1C must be checked "yes.")

___yes ___no Student understand 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 of teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used medication.

Step 2 – Emergency Calls

Call 911 and state that a student has an allergic/anaphylactic reaction and request that paramedics transport the student to the hospital. Then contact parent/guardian.

Physician Signature _____ Date _____
Stamp or name, address and phone printed:

_____

_____

_____

END OF PHYSICIAN/ADVANCED PRACTICE NURSE SECTION_

SECTION 11 – TO BE COMPLETED BY PARENT/GUARDIAN

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

I hereby give permission for my child to receive 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. My child's Epipens shall be kept: _____

Date _____ Parent Signature _____

B. Parent authorization for the administration of epinephrine by designees/delegates (to be completed for all students for whom the physician/advanced practice nurse has completed Step 1B for epinephrine delegates and parent gives consent to trained delegate for their child)

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates/designees _____,
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 _____

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

1. I understand that the district and its employees or agent shall incur no liability as a result of any injury arising form 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 this 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 the epinephrine, at all times. Extra medication will be sent to school to be kept in the Health Office in case my child forgets to bring the medication prescribed.

Date _____ Parent Signature _____

D. Student Agreement for Self-Administration

I understand that 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 after school activities. I have been instructed on how to self-administer this medication and understand the side effects of improper use.

Date _____ Student Signature _____

E. Student Agreement for Delegate (Grades six through eight)

I understand that _____has volunteered to act as my delegate. I will stay with the delegate and follow the directions of the delegate al all times.

Date _____ Student Signature _____

SECTION III – TO BE COMPLETED BY SCHOOL ADMINISTRATOR

Reviewed and Approved by the School Administrator

Date _____ Administrator _____

SECTION IV – TO BE COMPLETED BY SCHOOLMEDICAL INSPECTOR

Reviewed and Approve by the School Physician:

Date _____ School Physician Signature _____

SECTION V – EMERGENCY CONTACTS

In the event the school nurse or delegate needs to contact you, please provide us with contact phone numbers in the order that we are most likely to reach you and indicate if this is a cell (c), work (w) or home (h) phone number.

1. _____	_____	_____	_____	
Parent/Guardian	(C, H, W)	(C, H, W)	(C, H, W)	
2. _____	_____	_____	_____	
Parent/Guardian	(C, H, W)	(C, H, W)	(C, H, W)	
3._____	_____	_____	_____	
Emergency contact	(C, H, W)	(C, H, W)	(C, H, W)	