

Self-administering Emergency Epinephrine and Antihistamine for Life-Threatening Allergy

Please note when prescribing for an anaphylaxis reaction the epinephrine auto-injector you prescribe will be given by a trained delegate if, for some reason, the student is unable to self-administer.

Student (Full Name): _____ D.O.B. ____/____/____ is under my care
for life-threatening anaphylaxis reaction to (list allergens): _____.

For food allergy –

Type of contact with food requiring epinephrine (check): ☐ ingestion ☐ touch ☐ inhalation

☐ Check box: Give epinephrine if the allergen was definitely eaten even if there are no symptoms.

School Nurse/Delegate: Give epinephrine: _____ IM in thigh. Call “911”.
Brand/Name of Epinephrine Auto-injector Dose

Expect Rapid Results: if not better in 5-10 minutes administer second epinephrine injection. YES NO

In addition to the above, may self-administer (after giving first injection of epinephrine) antihistamine:

Name of Antihistamine (oral): _____ Dose: _____

Medical Provider - Please Print (OR STAMP)

Medical Provider's Signature

____/____/____
Date

Street Address

City/Town, State

Zip Code

Telephone

Health Care Provider and Parent/Guardian, please emphasize the following responsibilities: Do not share medication with others. Medications need to be labeled in the original container with name of medication, dose and student name. Only the dose of medication that needs to be taken during the school day should be carried by the student. Although not required, it is strongly suggested, the student wear a medical alert necklace or bracelet.

Parent/Guardian completes this section: My child has my permission to self-administer the above named medication(s) as directed by the physician. I understand that the Cape May County Technical School District shall incur no liability or claims against the district or its employees as a result of injury arising from my child's use of the self-administered medication nor as administered by the school nurse and/or trained delegate. I give permission for the school nurse to share this information with pertinent school staff.

Parent/Guardian Name - **Print:** _____ Signature: _____ Date: _____

Circle

Number to call first: **Home:** _____ **Work:** _____ **Cell:** _____

Other Emergency contact:

Person Name: _____ Relationship to student: _____ Phone(s): _____

Student completes:

I acknowledge that I am to have the above prescribed medication in my possession at all times before, during and after school and use it in the manner prescribed by my physician. I understand that my medication cannot be shared with anyone else.

Student signature: _____ Date: ____/____/____

Cape May County Technical School

Dear Parent/Guardian,

N.J.A.C. 6A:16-2.1 allows auto-injector epinephrine administration for life threatening reactions and includes the training of designated school employees, as trained by the school nurse, to administer epinephrine in such an emergency. The medical plan to manage life-threatening allergy for your child while in school, and school sponsored activities, needs to be updated annually. If your child is in a sport or other after school activity it is important that you or your child mention his/her health condition to the adult in charge of that activity. You should also inform your child's bus driver.

If possible, please supply a spare auto-injector epinephrine device (ie. Epinephrine Auto injector, EpiPen/Auvi-Q) to the school nurse for placement in the emergency box in the event your child forgets to carry his/her emergency epinephrine. For the health and safety of your child please encourage him/her to carry their emergency epinephrine, and one dose of antihistamine (if prescribed).

Please have your child's physician complete the attached medical orders.
It is suggested that your child wear a Medical Alert bracelet or necklace.

School policy prohibits the carrying of more than one dose of antihistamine.

Thank you,
Lynda Zipparo, School Nurse

Checklist for parent use:

- ☐ I have supplied the school nurse with completed and signed medication orders.
- ☐ Epinephrine auto-injector (student may need two dose pack) was supplied to my child with a valid expiration date. Expiration: date ____/____/____.
- ☐ Optional: One spare Epinephrine auto-injector device with valid expiration date was supplied to the school nurse for inclusion in the emergency kit for delegate to administer as needed.
- ☐ I have informed my child's bus driver
- ☐ I have reminded my child to keep one dose of epinephrine with him/her at all times.
- ☐ I have reminded my child to keep one dose of antihistamine with him/her at all times.
or ☐ Antihistamine is not prescribed.
- ☐ When my child is in a club, staying after school, on a field trip, involved in sports or other activity outside of the building, I will inform the person in charge of that activity/event of my child's allergy.