Manville Public Schools Health Offices
Allergy and Anaphylaxis Medication Orders and Emergency Care Plan
School Year:

Name of student: _____ **DOB**: _____

This student has a documented life threatening allergy to the following (indicate):

_____

_____

_____

If there is reasonable suspicion that this child has been stung, has ingested the above named allergen, or if signs of anaphylaxis develop, I give permission for the nurse or trained delegate to follow the protocol described below.

☞ **Healthcare Provider Check One**:

☐ I certify the student has been trained **and is capable** to self-administer epinephrine via a pre-filled auto-injector.

☐ I certify the student is not capable of self-administration and requires the school nurse or trained delegate to administer epinephrine via a pre-filled auto-injector.

Epinephrine Auto-injector (Specify brand, dose, route):_____

☐ **Administer Immediately**

☐ **Administer <u>only</u> if signs of anaphylaxis develop**
Prescriber may indicate specific signs: _____
_____
_____

If an antihistamine is ordered to be given <u>in addition</u> to the epinephrine, indicate medication, dose, route:

_____

_____

<u>Call 911 and parent immediately</u>.

OFFICE STAMP

_____ _____ _____

Signature of Healthcare Provider **Date** **Office Telephone**

Parent/Guardian Permission for Administration of Epinephrine via Delegate

I understand that if my child is unable to self-administer epinephrine via a pre-filled auto-injector, a delegate selected and trained by the school nurse may administer epinephrine via a pre-filled auto-injector if the school nurse in not available. I acknowledge that if the requirements of N.J.S.A. 18A:40-12.5 and 12.6 P.L. 1997, c.368 are followed; including that the delegate may or may not be certified to perform cardiopulmonary resuscitation; the Board, its employees, and agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I will indemnify and hold harmless the Board, its employees, and agents against any claim arising out of the administration of the epinephrine to my child. I understand that this permission is effective for the **<u>current</u>** school year only and must be renewed for each subsequent school year. It is my responsibility to provide the school nurse with written orders from a physician for the administration of epinephrine and to provide the medication and/or replacement as necessary.

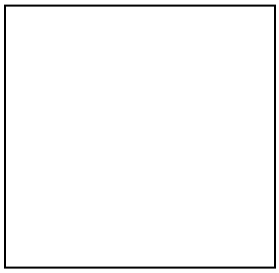
Parent/Guardian Signature: _____ Date: _____

Please complete other side of this document ➔

Anaphylaxis Emergency Plan of Care and Contact Form

Student: _____ D.O.B.: ___/____/_____ Grade: _____
Allergy: _____

Does the student have medical documentation of Asthma? ☐Y ☐N


Student Picture

Signs of Anaphylaxis can include the following:
Lung (Respiratory): Shortness of breath, wheezing, repetitive cough
Heart: Pale or bluish color, faint, weak pulse, dizziness
Throat: Tightness, hoarse, difficulty breathing or swallowing
Mouth: Swelling of lips/tongue, numbness, itchiness
Skin: Hives, widespread redness
Abdomen/Stomach: Vomiting, diarrhea, nausea
Other: may feel anxious, feeling of something bad happening

INJECT EPINEPHRINE IMMEDIATELY. DO NOT HESITATE TO ADMINISTER.

- Initiate 9-1-1
- 911 must be called if epinephrine is given.
  State that an anaphylactic reaction has been treated and emergency medical services are required.
- Monitor the student, position to comfort. Consider lying on back with legs elevated, lying on side if nausea/vomiting, or sitting more upright if difficulty breathing.
- Contact the parent/guardian.
- Contact the building administrator/designee.

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

I approve this allergy/anaphylaxis care plan for my child and give permission for this plan to be followed by school personnel. I give consent for the sharing of information as needed. I assume full responsibility for providing the school with the prescribed medication(s).

Parent/Guardian Name: _____
Parent/Guardian Signature: _____ Date: _____

School Nurse: _____ Date: _____