SCOTCH PLAINS-FANWOOD SCHOOL DISTRICT
MEDICAL ORDERS AND EMERGENCY HEALTH CARE PLAN FOR SIGNIFICANT ALLERGIC REACTIONS

Student's Name Date of Birth Grade/Teacher

Place Student's Picture Here

PHYSICIAN'S ORDERS & INSTRUCTIONS:

SEVERE ALLERGY TO: _____

Student's known symptoms: _____

Is the student asthmatic? Yes* _____ No_____ (* High risk for severe reaction)

SECTION 1: MEDICAL ORDERS FOR TREATMENT

CHECK THE APPROPRIATE BOX BELOW:

- ❑ Give antihistamine immediately after suspected contact with, or ingestion of, allergen and follow with epinephrine if symptoms progress to severe.
- ❑ Give epinephrine **only** immediately after suspected contact with, or ingestion of, allergen regardless of presenting symptoms.

Mild Symptoms Only: Mouth: Itchy mouth Skin: A few hives around mouth/face, mild itch Gut: Mild nausea/discomfort	→	**Give antihistamine** • Student may self administer if age appropriate. • Stay with student. Contact parent for transport home. • If symptoms progress, administer the epinephrine and call 911.
Severe Symptoms: One or more of the following symptoms are present or a combination of symptoms from different body systems: Lung: Short of breath, wheezing, repetitive cough Heart: Pale, blue, feels faint, weak pulse, dizzy, confused Throat: Tight, hoarse, trouble breathing or swallowing Mouth: Obstructive swelling of tongue or lips Skin: Hives, itchy rash, swelling of face or eyes Gut: Vomiting, diarrhea, cramping pain	→	**Inject epinephrine immediately** • Student may self administer if age appropriate. • Stay with student. • Call 911 and request the paramedics. Contact the parent. Student must be transported to the ER. • Position student for comfort and to aide breathing and prevent aspiration of vomited materials. • May repeat dose of epinephrine in 15 minutes if symptoms persist or worsen. • Document incident.

DOSAGE:

Epinephrine: Inject intramuscularly (check one)

❑ Epi Pen 0.3mg	❑ Epi Pen Jr 0.15mg	❑ Auvi-Q 0.3mg	❑ Auvi-Q 0.15mg

Oral Antihistamine:

❑ Benadryl 12.5mg q __hrs	❑ Benadryl 25 mg q ___hrs	❑ Benadryl 50 mg q ___hrs	❑ Other:

Possible side effects of medication:_____

Important: asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Conditions for administering medications: (check one)

- ❑ **Independently.** Child has been trained and is proficient in self-administrating medication and is aware that he/she may not share medication with anyone else. Only students in **grade 5-12** are eligible for independent self-administration.
- ❑ **Administration by the nurse, delegate or parent.**

_____ _____ _____ _____

Physician's Name/Stamp **Physician's Signature** **Phone** **Date**

SECTION 2: EMERGENCY RESPONSE

1. Immediately call the nurse at ext_____ or delegate (see below) and inform him/her of the situation and location of the student. If the school nurse or designate is not available, **CALL 911 and state a student may be having a severe allergic reaction and ask for the paramedics. During the school day the main office can do this.**
2. Call the main office at ext_____ to advise of the situation. Give the student's name, location and problem: **Severe allergic reaction.**
3. Upon arrival, the school nurse or trained designee will evaluate the student and administer the medication (if the student has not already done so) as per physician's order (on page 1) and immediately call 911.
4. Calmly reassure student. Have student lie down to rest. If student becomes unconscious, assist to floor and position on side. Stay with student until help arrives.
5. Notify the parent/guardian
6. Any student receiving Epinephrine will be sent to the nearest hospital even if the parent cannot be reached. The used Auto injector should be given to the paramedics/rescue squad disposal. Document time epinephrine was given.

EMERGENCY CONTACT NUMBERS

Parent/Guardian_____ Home # _____
Cell #_____
Work # _____

Parent/Guardian _____ Home # _____
Cell # _____
Work # _____

Other: _____ Home #_____
(name and relationship to student) Cell #_____
Work # _____

SECTION 3: PARENT PERMISSION

I give permission for my child to be treated for a severe allergic reaction and, if age appropriate (grades 5-12) and doctor approved, to carry and self-administer the medication prescribed while on school property or off school property at an approved school event. In addition, I give permission for my child's athletic coach/club advisor/music director/teacher to serve as the trained epinephrine delegate for my child during after school and weekend activities, or during field trips when the school nurse is not present.

I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. A duplicate of this medication is to be sent into the school in the original pharmacy labeled container and kept in an available location for the nurse and delegate

I understand that this contract is to be reviewed annually at the beginning of each school year. Permission to self-administer this medication shall not be construed as permission to self-administer other medication.

I hereby release and hold harmless the Scotch Plains-Fanwood Board of Education, its agents, servants and employees from any and all liability for damages which may result to the student, his/her servants and representatives from claims arising from the diagnosis and treatment/administration of a pre-filled epinephrine auto-injector to my child.

Parent/Guardian Signature:_____Date_____

SECTION 4: STUDENT CONTRACT (GRADES 5-12)

I understand that I will use this medication as directed by my physician. I will be responsible and discreet in using this _____ and should have this medicine readily accessible.
(name of medication)

I have been instructed how to self administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else. After each use I will notify the nurse. I understand that if I do not abide by these regulations I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of each school year.

Student's Signature:_____ Date:_____

SECTION 5: RELEASE OF CONFIDENTIAL HEALTH INFORMATION

The Emergency Health Care Plan containing written information regarding your child's medical health needs cannot be shared with any staff members without the written permission of the parent/guardian. Please check off the appropriate boxes below so that the school may best meet both the medical and educational needs of your child.

- ❑ A copy of the Emergency Health Care Plan regarding my child may be given to the following staff members:
  - ❑ Classroom teachers
  - ❑ School Counselor
  - ❑ Child Student Team Case Manager (if applicable)
  - ❑ Principal/Principal's designee
  - ❑ Food Services (food related allergy only)
  - ❑ Bus drivers
  - ❑ Other_____
    (extra-curricular activities i.e.: sport coaches, club advisers- parent responsible for notifying nurse of these names when student joins the extra-curricular activity.)
- ❑ I do not want the Emergency Health Care Plan regarding my child to be distributed.

_____

Signature of Parent/Guardian Date