

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 **only if signs of anaphylaxis develop** Prescriber may indicate specific signs: _____

If an antihistamine is ordered to be given **in addition** to the epinephrine, indicate medication, dose, route:

Call 911 and parent immediately.

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 is 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 **current** 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*

Rev 06/2017
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

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 Student Picture 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: _____