

VOORHEES HIGH SCHOOL, 256 Route 513, Glen Gardner, NJ 08826
Nurse phone: (908) 638-2148 Nurse Fax: (908) 638-2188

MEDICATION FORM /EMERGENCY HEALTH PLAN for ALLERGIC REACTION

This form must be completed by a physician and parent annually for any student requiring Epinephrine while in school or at a school-sponsored event.

Student's Name: _____ DOB: _____ Grade: _____

Allergy to: _____

Signs of past allergic reaction have included (please circle):

<u>Systems</u>	<u>Symptoms</u>
Mouth	Itching and swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash and/or swelling about the face or extremities
GI	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing and/or wheezing
Heart	"Thready" pulse, fainting, pale, blue color
General	Sudden fatigue, general panic, fear of impending doom, chills

All above symptoms can potentially progress to a life-threatening situation!

DO NOT HESITATE TO ADMINISTER EPINEPHRINE OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

SECTION I-TREATMENT – To be completed by the physician/advanced practice nurse:

Patient can self-medicate and I acknowledge that this student has been instructed in and understands the proper method of self-administration of this medication.

Patient cannot self-medicate. The nurse or designee should administer the medication as ordered.

1. Due to the rapid progression of anaphylaxis and the critical need for immediate availability, I authorize _____ (student's name) to carry the epinephrine auto-injector on his/her person in school and to school events.
2. Student, Nurse or Designee should administer epinephrine _____ (dosage) intramuscularly via an auto-injector immediately.
3. Other medications should also be administered:

_____ (medication, dosage, route)
_____ (medication, dosage, route)
4. Call 911. Inform dispatcher that the student is experiencing a severe allergic reaction. Student must be transported to nearest hospital.
5. Notify parents/guardians.
6. Epinephrine may be repeated in _____ minutes for recurring or worsening symptoms.

Physician Signature: _____ **Date:** _____

Physician Stamp:

SECTION II- To be completed by parent/guardian:

My child, _____, a student at VHS, has a potentially life-threatening allergy that could result in anaphylaxis. This student requires emergency administration of epinephrine by a pre-filled single dose auto-injector mechanism containing epinephrine in the event of anaphylaxis and has my permission, in accordance with P. L. 2007, c 57, to carry and self-administer the prescribed medication.

In order to keep my child safe at school or a school sponsored event, I consent to the following for the 20____/20____ school year:

- I will assure that the medication is available and in its original prescription container.
- I will remind my child to have the medication with them at all times.
- My child is aware of his/her known allergens and that he/she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to an adult immediately.
- 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 prescribed medication to school.
- I give permission for my child to receive medication at school as prescribed by my child's physician.
- I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.
- I give permission for the school nurse to share this medical information with members of the NHVRHS staff who have direct responsibility for my child in school or at a school sponsored event.
- I authorize the administration of epinephrine via auto-injector to my child by a designated staff member trained by the school nurse. Their assistance will only be needed if my child should experience an allergic/anaphylactic reaction in school or a school sponsored event and the school nurse is not present at the scene.
- **I understand that the NHVRHS district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration of medication by the pupil, and we, the parents or guardians, indemnify and hold harmless the NHVRHS district and its employees or agents against any claims arising out of the administration or self-administration of medication by the pupil. Any person who acts in good faith in accordance with the requirement of P.L. 2007, c 57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that section.**
- I will contact the school nurse with any questions or changes in my child's health condition.

Parent Signature _____ Date _____

Emergency Numbers:

Mother _____ Home# _____ Work# _____

Father _____ Home# _____ Work# _____

Emergency Contacts (if unable to contact parents):

1. _____ phone # _____

2. _____ phone # _____

MD _____ phone# _____