NORTH HUNTERDON-VOORHEES HIGH SCHOOL-SCHOOL YEAR 20____ TO 20____

MEDICATION FORM FOR ALLERGIC REACTION-complete both sides

This form must be completed by a PHYSICIAN/ADVANCED PRACTICE NURSE AND PARENT ANNUALLY for any student requiring Epinephrine while in school or at a school-sponsored event.

Student's Name:_____ DOB:_____ Grade:_____
ALLERGY TO: _____
Asthmatic Yes* ( ) No ( ) *Higher risk for severe reaction
Location of epinephrine(check all that apply): _____ with student _____ with nurse _____ other_____

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

Symptoms (The severity of symptoms can quickly change!) **Give Checked Medication**

	If food allergen has been ingested or student has been stung by an insect (if order is for insect sting allergy), but no symptoms	( ) Epinephrine	( ) Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	( ) Epinephrine	( ) Antihistamine
Skin	Hives, itchy rash, swelling on face or extremities	( ) Epinephrine	( ) Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	( ) Epinephrine	( ) Antihistamine
General	Panic, sudden fatigue, chills, fear of impending doom	( ) Epinephrine	( ) Antihistamine
Throat †	Tightening of throat, hoarseness, hacking cough	( ) Epinephrine	( ) Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	( ) Epinephrine	( ) Antihistamine
Heart †	Thready pulse, passing out, fainting, pale, blueness	( ) Epinephrine	( ) Antihistamine
	If reaction is progressing (several of the above areas affected)	( ) Epinephrine	( ) Antihistamine

† Potentially Life Threatening

DOSAGE

Epinephrine: Inject intramuscularly (circle one): EpiPen (0.3 mg) EpiPen Jr. (0.15 mg) Auvi-Q (0.3 mg) Auvi-Q Jr. (0.15 mg)

Epinephrine may be repeated in _____minutes

Antihistamine: give_____
Medication/dose/route

Other: give _____
Medication/dose/route

CALL 911- state "a student had a severe allergic reaction, and additional epinephrine may be needed! Please send paramedics". Student must be transported to the nearest hospital. Then call parents.

TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT (Please check one answer):

P.L. 2007, c 57 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine to a student who has anaphylaxis when a nurse is not physically present at the scene.

_____ **Delegate Order- For suspected exposure to allergen(s) listed above**, delegates are to immediately administer prescribed auto-inject epinephrine. (Note: Delegates will not be able to administer an antihistamine as the first treatment)

_____ **This student's order should not be delegated**

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Please check all that apply):

P. L. 2007, c 57 directs that a student may be permitted to self-administer medications for potentially life threatening illness provided proper procedures are followed.

_____ This student has a potentially life-threatening allergy and will carry epinephrine at all times in school or when attending a school sponsored event

_____ This student understands, has been instructed, and is capable of the proper technique of self administration of the prescribed medication(s)

_____ This student is aware 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

Physician Signature:_____ Date:_____ Physician Stamp:

ALLERGIC REACTION / MEDICATION FORM

SECTION II- To be completed by parent/guardian:

My child, _____, a student at NHHS, 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 in its original prescription container.
- I understand that it is my responsibility to ensure that the student has the medication with them at all times.
- I will be responsible for noting expiration date and replacing expired medication.
- 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 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/or staff, 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 and/or staff. 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/Guardian's Name Parent/Guardian's Name

_____ _____

Parent/Guardian's Signature Parent/Guardian's Signature

_____

Date

Emergency contacts – Name/Relationship (List parent/guardians first) – Telephone numbers

1. _____ (H) _____ (C) _____ (W) _____

2. _____ (H) _____ (C) _____ (W) _____

3. _____ (H) _____ (C) _____ (W) _____

NORTH HUNTERDON-VOORHEES REGIONAL HIGH SCHOOL DISTRICT

Student Name:_____ Date of Birth:_____

Designation of Administration of Epinephrine

The certified school nurse may designate, in consultation with the Building Administrator, another employee of the district to administer a pre-fiilled single dose auto-injector mechanism containing epinephrine when the school nurse is not physically present at the scene. The employee(s) will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.

Delegates are assigned according to activity-sports, activities & trips

(PLEASE CHECK ONE ANSWER)

_____I give consent for a trained employee(s) of NHHS to administer epinephrine in the event the school nurse is not present at the scene. I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine, and that I indemnify and hold harmless the District and its employees or agents against any claims arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine.

_____I do not consent for an employee to be designated as an epinephrine delegate for my child.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____