WASHINGTON TOWNSHIP
SCHOOL DISTRICT

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ALLERGY & ANAPHYLAXIS ACTION PLAN

Student Photo

MEDICATION FORM FOR LIFE THREATENING ALLERGIC REACTION

This form must be completed and signed by the student's physician/health care provider and signed by parent/guardian.

Student Name ___________________________________ DOB ____________ Gr_____

SECTION I - TO COMPLETED BY THE PHYSICIAN/HEALTHCARE PROVIDER

Allergen(s) ____
Symptoms in past ____
Epinephrine required in past? ☐ Yes ☐ No

Is this a potentially life-threatening allergic reaction? ____YES ____ NO
Is this student asthmatic? (higher risk for severe reaction) ____YES ____ NO
Has allergy testing been completed? ____YES ____ NO

A. Treatment When the Nurse is Present

Symptoms:	**Give checked medication:**
1. Know exposure to allergen **but *no symptoms***:	____ Epinephrine ____ Antihistamine
2. Mouth (itching, tingling or swelling of the lips, tongue, mouth)	____ Epinephrine ____ Antihistamine
3. Skin (hives, itchy rash, swelling of the face or extremities)	____ Epinephrine ____ Antihistamine
4. Gut (nausea, abdominal cramps, vomiting, diarrhea)	____ Epinephrine ____ Antihistamine
5. Throat (tightening of throat, hoarseness, hacking cough)	____ Epinephrine ____ Antihistamine
6. Lung (shortness of breath, repetitive coughing, wheezing)	____ Epinephrine ____ Antihistamine
7. Heart (thread pulse, low BP, fainting, pale, cyanosis)	____ Epinephrine ____ Antihistamine
8. If reaction is progressing (several of the above areas affected)	____ Epinephrine ____ Antihistamine
9. Other ____	____ Epinephrine ____ Antihistamine

Dosage:

Epinephrine (Inject intramuscularly): BRAND ________________________ DOSAGE ____________
Epinephrine may be repeated, if necessary, in _______ minutes.
Antihistamine: give (medication, dose, route) ____________________________________
Other: give (medication, dose, route) ____

COMPLETE ALL PAGES

B. Treatment by Delegate When the Nurse is NOT Present - NJ PL 2007 c 57 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene.
(1 OR 2 MUST BE COMPLETED)

1. __ **Delegate Order** - For suspected exposure to allergen(s) listed above and showing signs of an allergic reaction, delegates are to immediately administer epinephrine (check one):

☐ **EpiPen** ☐ **EpiPen Jr.** ☐ **Twinject 0.3mg** ☐ **Twinject 0.15mg** ☐ **Auvi Q 0.15mg** ☐ **AuviQ 1.30mg**

NOTE: *Delegate may only give first dose of Epinephrine then 911 will be called immediately.*

2. __ **This student's order should not be delegated.**

C. Treatment by Student (Self-Administration) - NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction, provided proper procedures are followed.

____ ***Yes** ___**No (Check one) Student may self-administer the medication prescribed (epinephrine and antihistamine)?**

(*If yes, please complete the questions below. In order to have permission to self-administer, all questions in Step IC must be checked "yes.")

___**Yes** ___ **No** Student understands the purpose, proper technique of administration and frequency of use of the medication prescribed above and is capable of self-administration of the medication.

___**Yes** ___ **No** Student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used medication.

EMERGENCY CALLS

► **Call 911 and state that a student has allergic/anaphylactic reaction and request that paramedics transport the student to the hospital.**

► **Contact the parent/guardian.**

If a student should suffer an anaphylactic reaction and neither the school nurse, nor the delegate is available, the emergency medical system (911) will be activated.

This order is valid from September 1, _______ through August 31, _____

********** All Medication Orders Must Be Renewed Annually***********

____

Physician/Healthcare Provider's Signature

Date ________________

____

OFFICE STAMP

(END OF PHYSICIAN/HEALTHCARE PROVIDER SECTION)

SECTION II – TO BE COMPLETED BY PARENT/GUARDIAN

A. Parent Authorization (to be completed for all students)

I hereby give permission for my child to receive medication at school as prescribed above by their physician/healthcare provider. I also give permission for the release and exchange of information between the school nurse and my child's physician/healthcare provider concerning any health matters and medications. In addition, I understand that this information will be shared with school staff on a need-to-know basis.

Parent Signature____ Date ____________________

B. Parent authorization for the administration of epinephrine by designees/delegates (to be completed for all students for whom the physician/healthcare provider has completed Section 1 B for epinephrine delegates.)

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates/designees trained by the certified school nurse to administer epinephrine in the event the school nurse is not present at the scene. I understand that neither the district nor any of its employees shall be liable for any injury resulting from the administration of epinephrine to a student and I agree to indemnify and hold harmless the district and its agents against any related claims.

Parent Signature____ Date _____________________

C. Parent Authorization (for students with physician permission to self-administer medication)

1. I understand that neither district nor any of its employees shall be liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless the district and its agents against any related claims.

Parent Signature____ Date _____________________

2. I give permission for my child to self-administer medication as prescribed on this form for the current school year as I consider him/her to be responsible and capable of self-administration of medication. Medication must be kept in its original prescription container. I understand my child is to keep the medication for self-administration with him/her at all times. 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.

Parent Signature____ Date _____________________

Hospital Preference ____

Physician's Name _________________________________ Phone #:__________________________________

Parent/Guardian ___________________________ Phone#: ________________ Relationship: ____________

Emergency Contacts l . ______________________ Phone#: ________________ Relationship: ____________

2. ______________________ Phone#: ________________ Relationship: ____________

Student's Name: _________________________________ Grade/Teacher: ______________________________

Please review and check your choices for your child:

I ☐ **DO /** ☐ **DO NOT** wish to have my child seated at the nut-aware and/or milk and nut-aware table in the student lunchroom. I understand that, although the tables are washed in-between lunch periods, residue may remain on the table and seats from a previous lunch.

_____ My child may purchase lunch in the cafeteria. *If you wish for your child to purchase lunch, it is strongly advised that you contact food service personnel to review ingredient labels of the food served in the cafeteria to be sure it is safe for your child.*

_____ My child is to eat *only* foods sent from home.

_____ Contact me regarding class parties/event snacks and I will advise you in writing if my child may eat it. I will send in a supply of alternate snacks for my child in the event that the food item is not appropriate for my child.

I understand that information on my child's allergy is shared with staff on a need-to-know basis. Copies of the Emergency Care Plan (ECP) will be placed in the sub folders of the education staff and School Nurse, and a copy given to Transportation Coordinator for the bus drivers.

____ ____________________________

Parent/Guardian Signature Date

(END OF PARENT/GUARDIAN SECTION)

For office use only:

Date received from parent: ________________________

Student has permission to carry medication: YES NO

Medication carried: ________________________________

School Nurse signature: ____________________________

Date ECP sent to Transportation: _____________________

Date ECP sent to teacher: ____________________________