EDISON TOWNSHIP PUBLIC SCHOOLS
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HS #30A

PHYSICIAN'S ORDER FOR SEVERE ALLERGY EMERGENCY TREATMENT
SCHOOL YEAR 20__- 20__

Student's name _____ Birth date _____ Grade/Homeroom _____

Severely allergic to: _____ Asthmatic? ____ Yes ____ No

Previous episode of anaphylaxis ☐ No ☐ Yes If yes, when: _____

Emergency Contact:
Name:_____ Relationship: _____ Phone: _____

MEDICATIONS

ANTIHISTAMINE: Name _____ Dose (mg)_____

Give antihistamine for any one of the following checked symptoms:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
☐ Other _____

EPINEPHRINE AUTOINJECTOR: ☐ Epi-Pen 0.3mg ☐ Epi-Pen Jr. 0.15mg ☐ Other _____
☐ Auvi-Q 0.3mg ☐ Auvi-Q 0.15mg

Give epinephrine for any one of the following checked symptoms:

Give 2nd dose of epinephrine if: (specify time & symptoms)

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling _____
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat _____
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea _____
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin _____
☐ Other _____

(Second dose ONLY will be administered by School Nurse or RN)

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Choose ONE administration order:

_____ 1. Give Epinephrine only ☐ *Delegate available will be assigned*
_____ 2. Give Antihistamine and Epinephrine at the same time ☐ **Delegate available will be assigned*
_____ 3. Give Antihistamine first, observe and give Epinephrine as ordered ☐ **Delegate available will be assigned*

***Please note – in the absence of a school nurse, if available, a trained delegate will give Epinephrine and any antihistamine order will be disregarded. IF NO NURSE OR DELEGATE, 911 WILL BE CALLED IMMEDIATELY.**

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1. ☐ This student has been trained and is capable of self-administration of the following medication(s) named above.

☐ Epinephrine – single dose unit ☐ Epinephrine & Antihistamine – single dose units *(for Order Option #2 only)*

***Under NJ state law, orders for antihistamine alone cannot be self-administered.**

2. ☐ This student is NOT capable of self-administration of the medications named above.

Physicians' signature: _____ **Phone:** _____

Date _____ **Stamp** _____

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use as prescribed. Any antihistamines and/or epinephrine medication must be brought to school by an adult, and be provided in the original labeled container/packaging. A back-up epinephrine auto-injector will be requested. ***(NOTE: A double pack of epinephrine auto-injectors is requested)***

Select ONE to sign and date:

1. I verify that my child, _____ has a potentially life threatening illness and **has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self-administer prescribed medication**. I further acknowledge that the Edison Township School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by Edison Township School District are followed, Edison Township School District shall have no liability as a result of any injury arising from the self-administration of the epinephrine auto-injector, and I shall indemnify and hold harmless the Edison Township School District and it's employees or agents against any claims arising out of self-administration of medication by my child.

2. I verify that my child, _____ has a potentially life threatening illness and is **UNABLE to self-administer the prescribed medication** in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Edison Township School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Edison Township School District are followed Edison Township School District shall have no liability as a result of any injury arising from the self-administration of the epinephrine auto-injector, and I shall indemnify and hold harmless the Edison Township School District and its employees or agents against any claims arising out of administration of medication to my child.

_____ _____

Signature of Parent/Guardian **Date**

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Please sign acknowledgement:

1. I understand that as per NJ state law every effort will be made to secure a trained delegate to administer epinephrine auto-injector to my child **in the absence of a school nurse**. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and Epinephrine auto-injector will be administered by the trained delegate. **If no nurse or delegate is available (including class trips), 911 will be called.**

2. I will contact the school if my child is attending any school-sponsored activity outside of regular school hours without an accompanying parent/guardian.

3. I give permission for the exchange of information between the school nurse, my child's physician and staff members with direct responsibility for my child in school or school activities.

_____ _____

Parent Signature **Date**

SCHOOL USE ONLY

Trained delegate employees/Room #

_____

_____

_____

_____

_____

_____

Signature of Principal

Location of Epinephrine Auto-injector(s)

____ **Health Office**

____ **Principal's Office**

____ **Student**

____ **Classroom(s)** _____

____ **Other** _____

_____

Signature of School Nurse

6/08, 5/09, 4/13