The Village School Est. 1977
Montessori Education

Physician's Orders for Allergy Emergency Treatment
Individualized Emergency Care Plan

Student's Name: _____
Birth Date: _____Class:_____

Physician's Orders: (To be filled out by Physician)

The above student is allergic to _____
Previous episode of anaphylaxis ____ Yes _____ No
If yes, please explain_____
History of asthma ____ Yes _____No
If yes, supply **Asthma Action Plan**

MEDICATIONS

Antihistamine: Name _____ Dose: _____

Give antihistamine for the following symptoms:
_____
_____
_____

Epinephrine: ___ EpiPen ____ EpiPen Jr. _____ Other _____

Give Epinephrine for the following symptoms:
_____
_____
_____

Choose one administration order:
___ Give Anthihistamine first, observe, for further symptoms and give Epinephrine PRN
___ Give Antihistamine only
___ Give Epinephrine only

___ This student has been trained and is capable of self-administration of the following medication(s)
___ Epinephrine – single dose unit

___ This student is not capable of self-administration of the medications named above.

Please Note: Under NJ state law, in the absence of a school nurse, a trained delegate will give epinephrine only, any antihistamine order will be disregarded.

Physician's Name: _____Date_____

Physician's Signature:_____

Physician's Address: _____

Physician's Phone: _____Fax _____

Authoriztion: To Be Filled Out By Parent:

I authorize the school nurse/principal/administrator to contact my physician on any questions related to the care of my child's care. I also authorize the school nurse or other unlicensed assistive individuals educated by the nurse to administer the above medication to my child during regular school hours and at other times when my child is participating in a school related event. I authorize my child to engage in self-administration if appropriate. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; and that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, school nurse and other school employees against any claims arising from the administration to my child.

Child's Name: _____

Parent's Name: _____

Signature: _____Date_____
(Parent/Guardian)