American Academy of
Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

	Symptoms of Anaphylaxis
MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one): ☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**
☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**
☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date

PEQUANNOCK TOWNSHIP SCHOOL DISTRICT
EMERGENCY ADMINISTRATION OF EPINEPHRINE
STATEMENT OF INDEMNIFICATION

1. I am the parent or guardian of _____, a student currently enrolled in the Pequannock Township Public Schools.
2. I have provided to the Board of Education, through its administration, written certification from _____'s physician or advanced practice nurse attesting to the fact that _____requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.
3. On _____, I provided to the Board of Education, through its administration, a current pre-filled, single dose auto-injector mechanism containing epinephrine for the use of my child, _____. The epinephrine I provided is due to expire on _____. I understand that epinephrine can only be obtained through a prescription and that I am fully responsible for keeping track of the expiration date of said epinephrine and replacing the same with another pre-filled, single dose auto-injector mechanism containing epinephrine when it has expired.
4. When required, and in accordance with the procedures specified by N.J.S.A. 18A:40-12.5 and N.J.S.A. 18A:40-12.6, I hereby consent, via this writing, to the administration of this pre-filled, single dose auto- injector mechanism containing epinephrine, which I provided to the Board of Education, to my child, _____.
5. The Board of Education, through its administration, has informed me in writing that if the procedures specified in N.J.S.A. 18A:40-12.5 and N.J.S.A. 18A:40-12.6 are followed, the Board and/or its employees or agents shall incur no liability as a result of any injury arising out of its administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child, _____.
6. This statement acknowledges that where the procedures specified in N.J.S.A. 18A:40-12.5 and N.J.S.A. 18A:40-12.6 are followed, the district shall have no liability and further acknowledges that I shall hereby indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child, _____.
7. I understand that the permission being granted for the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child is effective only for the school year for which such permission is granted and must be renewed for each subsequent school year.
8. I understand that, in accordance with N.J.S.A. 18A:40-12.6, the school nurse may designate, in consultation with the Board, or Superintendent, another staff member to administer epinephrine via an epi-pen when the nurse is not physically present at the scene. I further understand that, in accordance with N.J.S.A. 18A:40- 12.6(a), the designated staff member shall be properly trained in the administration of the epi-pen by the school nurse using standardized training protocols established by the Department of Education in consultation with the Department of Health and Senior Services.

_____ _____

Date Parent or Guardian's Signature

PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS
HEALTH OFFICE

AUTHORIZATION FOR STUDENT SELF-ADMINSTRATION OF MEDICATION

Dear Parent/Guardian,

You have indicated your child has a **LIFE-THREATING CONDITION** and requested that he/she be permitted to carry and self-administer required medication.

Pursuant to NJA.A.C. 6:29-3.2, and PequannockTownship Board Policy 5141.21, you are advised that the District shall not incur liability as a result of any injury arising from the self-medication.

I, _____, parent/guardian of _____
(Print Parents/Guardians Name) (Print Child's Name)

request that he/she be permitted to self-medicate _____
(Prescription)

for _____, and understand that the District cannot be held liable for
(Condition)

any injury incurring from this self- medication.

_____ _____
(Date) (Parent/Guardian Signature)

Please have your physician complete the next section:

I certify that the above student, my patient, has the potentially life-threatening condition indicated and in capable of, and has been instructed in the proper administration of the required medication

_____ _____
(Print Name) (Signature)

_____ _____
(Address) (Date)

_____

_____
(Phone number)

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