



**Consent and Agreement for Administration of Epinephrine Auto-Injector
According To New Jersey State Law and the Department Of Education Policy**

Student's Name: _____ D.O.B. _____

Grade: _____

I hereby give permission for my child to receive Epinephrine auto-injector during school hours on school premises, field trips, or extracurricular activities, as prescribed in the Allergy Action Plan and Delegate Orders. The school nurse or trained delegate in her absence will administer the school Epinephrine auto-injector according to Protocol and Implementation Plan, to any student without a known history of anaphylaxis, or any student whose parent or guardian has not met the requirements, or has not received the notice, when the nurse or delegate in good faith believes that the student is having an anaphylactic reaction. Pope John XXIII Middle School, the school nurse, the school delegates in the nurse's absence, and the school employees and agents shall have no liability as a result of any injury arising from the administration of the Epinephrine auto-injector to the student. The parents or guardians shall indemnify and hold harmless the Pope John XXIII Middle School, the school nurse, school delegates, employees and agents against any claims arising out of the administration of the Epinephrine auto-injector to the student.

The medication must be provided in its original prescription container properly labeled by the Pharmacist or Healthcare Provider. I also give permission for the release and exchange of information between the school nurse and my child's Healthcare Provider concerning my child's health and medications. I understand that this information will be shared with school staff on a need to know basis. I understand that it is my responsibility to provide a current Epinephrine auto-injector. I also understand that permission and Healthcare Provider's orders are effective only during the school year for which they are granted, and must be renewed each subsequent school year.

Parent/Guardian Signature: _____

Date: _____



Pope John XXIII Middle School – Allergy Action Plan

Student's Name: _____ D.O.B: _____ Grade: _____

ALLERGY TO: _____

Asthmatic Yes* ___ No ___ *Higher risk for severe reaction

Step 1: TREATMENT

Table with 2 columns: Symptoms and Give checked medication: (Determined by Healthcare Provider authorizing treatment). Rows include Mouth, Skin, Gut, Throat, Lung, Heart, and Other symptoms with corresponding medication options like Epinephrine and Antihistamine.

† Potentially life-threatening. The severity of symptoms can quickly change.

Epinephrine Auto-Injector (circle one): EpiPen 0.3mg EpiPen Jr. 0.15mg Auvi-Q 0.3mg Auvi-Q 0.15mg

Student can self-administer Epinephrine Auto-Injector (check one): ___ Yes ___ No

Antihistamine: Give _____ (medication/dose/route)

Other: Give _____ (medication/dose/route)

Step 2: EMERGENCY CALLS

- 1. Call 911 PARAMEDICS.....State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parents: _____ Phone Number: _____
3. Emergency Contact: _____ Phone Number: _____
4. Healthcare Provider: _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent/Guardian Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

Please use box for Healthcare Provider's Address Stamp



PARENT AUTHORIZATION:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the Healthcare Provider, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve Pope John Middle School of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the Healthcare Provider.

Parent/Guardian Signature _____ Date _____



Pope John XXIII Middle School – Delegate Orders

Student’s Name: _____ D.O.B: _____ Grade: _____

ALLERGY TO: _____

Asthmatic Yes* ___ No ___ *Higher risk for severe reaction

Step 1: TREATMENT

Symptoms: _____ Give checked medication: (Determined by healthcare provider authorizing treatment)

- If an allergen has not yet caused symptoms: ___ Epinephrine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth ___ Epinephrine
Skin – Hives, itchy rash, swelling of the face or extremities ___ Epinephrine
Gut – Nausea, abdominal cramps, vomiting, diarrhea ___ Epinephrine
Throat † – Tightening of throat, hoarseness, hacking cough ___ Epinephrine
Lung † – Shortness of breath, repetitive coughing, wheezing ___ Epinephrine
Heart † – Fainting, pale, blueness ___ Epinephrine
Other † – _____ ___ Epinephrine
If reaction is progressing (several of the above areas affected), give: ___ Epinephrine

† Potentially life-threatening. The severity of symptoms can quickly change.

Epinephrine Auto-Injector (circle one): EpiPen 0.3mg EpiPen Jr. 0.15mg Auvi-Q 0.3mg Auvi-Q 0.15mg

Student can self-administer Epinephrine Auto-Injector (check one): ___ YES ___ NO

Delegates are not permitted to administer antihistamines.

Step 2: EMERGENCY CALLS

- 1. Call 911 PARAMEDICS.....State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parents: _____ Phone Number: _____
3. Emergency Contact: _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent/Guardian Signature: _____ Date: _____

Healthcare Provider’s Signature: _____ Date: _____

Please use box for Healthcare Provider’s Address Stamp:



PARENT AUTHORIZATION:

In the event of a potentially life-threatening reaction, as described in the above Healthcare Provider’s order, I authorize the emergency administration of epinephrine via auto-injector to my child by the Pope John Middle School delegates who are trained according to Protocol and Implementation Plan. I indemnify and hold harmless Pope John Middle School, as well as its employees and agents, against any claims arising out of the administration of an epinephrine auto-injector to my child.

Parent/Guardian Signature _____ Date _____