MAHWAH BOARD OF EDUCATION
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Dear Parents,

According to the record on file, your child has a medical history of a severe allergic reaction that may require the administration of an Epinephrine Auto-Injector.

The Mahwah Board of Education, in keeping with State of New Jersey mandate, has developed a policy regarding the management of life threatening allergies in school.

According to this policy:

- **If a student has been trained by his/her family physician, that student may carry in school, and self-administer an epinephrine auto-injector should an anaphylactic reaction occurs.**
- **If the student is unable to, or chooses not to self-administer the medication, the school nurse, upon assessment, will administer epinephrine via auto-injector according to the physician's orders.**
- **Only the school nurse, acting on physicians' orders, may give Benadryl first, observe for further symptoms, assess according to the best nursing practices, and follow with epinephrine as necessary.**
- **In the absence of the school nurse, a delegate, who has been properly trained according to standardized training protocols, will immediately give the epinephrine auto-injector.** *(Please note: the delegate cannot give Benadryl first or make nursing assessments – the law specifies that a delegate is only permitted to administer the Epinephrine pre-filled auto-injector in a life threatening situation.)*

The attached form must be completed by the treating physician, signed by a parent, and returned to the school nurse in your child's school as soon as possible so that the MBOE is in compliance with New Jersey Public Law 1993.C30 and PL.1997,C38.

As with any medication, the Epinephrine Auto-Injector must be in the original container with your child's name on the box.

Thank you for your prompt attention

Sincerely,

Mahwah District School Nurses

MEDICATION AUTHORIZATION FOR SEVERE ALLERGIC REACTION ACCORDING TO P.L 1993.C308 AND P.L. 1997, C38
FOR SCHOOL YEAR _____ GRADE_____

Student's Name_____ D.O.B. _____ Date_____

Student has had "**A DOCUMENTED EPISODE OF ANAPHYLAXIS**": yes__ date: _____ no___

TO BE COMPLETED BY PHYSICIAN:

____If stung by_____
____After ingesting_____
____After exposure to_____

When School Nurse is Present*CHOOSE ONE**

___Give Benadryl p.o.(dose)_____ and observe student for up to 30 minutes followed by Epinephrine injector____(junior) _____(adult) if the following designated symptoms occur:

__Mouth----itching and/or swelling of lips, tongue, or mouth
__Throat-----itching and/or sense of tightness in throat, hoarseness, hacking cough, and/or difficulty swallowing
__Skin-------itching, hives, rash and/or swelling in any area of the body
__Gut--------nausea, vomiting, abdominal cramps, and/or diarrhea
__Lung------shortness of breath, sense of tightness
__Heart------rapid or weak pulse, dizziness and/or fainting
__Other:_____

OR

___Immediately give Epinephrine auto-injector _____ (junior) _____ (adult) whether or not symptoms are present.

__ Student may not self-administer
__ Student is capable of self-administration, has been instructed in its use, and may self-administer
__ Student may self-carry

****After Epinephrine Auto Injector is given, EMS will be contacted immediately ****

When School Nurse is not present:
In the event that the school nurse is unavailable, the Epinephrine auto-injector will be administered by the school delegate pursuant to statute. (The school delegate is not permitted to give Benadryl prior to administering the auto injector)
Parent Initial_____ Date_____

To be completed by Parent Guardian – I request that my child be given the medication described in the manner above at school by the school nurse or delegate. If my child is authorized to self-administer I, as his/her parent, will be aware of the expiration date and renew the injector when needed. I relieve the Mahwah Board of Education and its employees of any liability that may result from the administration of the above medication to my child, or from self-administration when certified by the physician.

Parent/Guardian Signature: _____ Date: _____
Home Phone: _____ Cell Phone _____ Other Phone_____

Physician's Signature: _____ Date: _____
Physician's Stamp:

Nurses may need to contact your physician for clarification.