

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  **Yes (higher risk for a severe reaction)**  **No**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_








**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:





## SEVERE SYMPTOMS

 <b>LUNG</b> Shortness of breath, wheezing, repetitive cough	 <b>HEART</b> Pale or bluish skin, faintness, weak pulse, dizziness	 <b>THROAT</b> Tight or hoarse throat, trouble breathing or swallowing	 <b>MOUTH</b> Significant swelling of the tongue or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy or runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea or discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

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**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

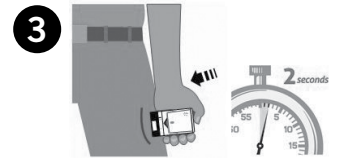
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_

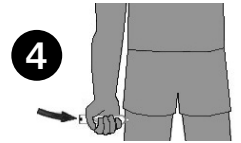
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



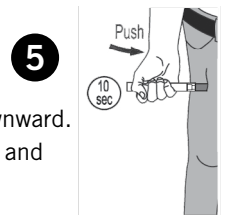
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

**2023-2024 PHYSICIAN/PARENT CERTIFICATION FOR  
STUDENT'S SELF-ADMINISTRATION OF MEDICATION**

**CERTIFICATION TO BE COMPLETED BY PHYSICIAN**

STUDENT NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

TIME AND CIRCUMSTANCES OF ADMINISTRATION: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

I certify that \_\_\_\_\_ has a potentially life threatening illness  
(Student)  
which requires the use of \_\_\_\_\_. I further certify that  
(Medication)  
\_\_\_\_\_ is capable and has been instructed in the proper method of  
(Student)  
self-administration of \_\_\_\_\_  
(Medication)

\_\_\_\_\_  
Signature of Physician Date

PHYSICIAN NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

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**CERTIFICATION TO BE COMPLETED BY PARENT**

I hereby authorize my son/daughter \_\_\_\_\_ to self-administer (Name  
of Medication) \_\_\_\_\_ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-  
administration of medication by (student name) \_\_\_\_\_.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising  
out of the self-administration of (medication) \_\_\_\_\_ by  
(student name) \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature Date

**SELF-ADMINISTRATION OF MEDICATION IN SCHOOL**

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially  
life threatening illness is allowed under guidelines established by the school and provided that the statutory  
requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A  
RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY  
A STUDENT.

Date:

To: Parents/Guardians:

Re: 2023-2024 Food Allergy & Anaphylaxis Emergency Care Plan

Please download, review, and sign the FARE (Food Allergy & Anaphylaxis Emergency Care Plan) form at <http://www.foodallergy.org/file/emergency-care-plan.pdf>. Please complete the entire form, obtain required signatures, and return to your child's school.

The FARE form addresses:

- **Severe Symptoms**
- **Mild Symptoms**
- **Medication/Doses**
- **Directions – Epipen Auto Injector**
- **Directions – Adrenaclick**
- **Directions – AUVI-Q**

In addition, please sign and return this memo along with the FARE form (which requires parent and physician signatures).

**As per parent/guardian of the student listed below, I understand that if the procedures as specified in N.J.S.A. 18A:40-12.6 are followed, the district or non public school shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district, non public school, and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.**

**Student's Name:** \_\_\_\_\_ **School:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_ Phone: \_\_\_\_\_

Thank you

# 2023-2024 MANDATORY MEDICATION FORM

**ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.**

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL.**

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NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

\_\_\_\_\_  
PARENT SIGNATURE/DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE/DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
TELEPHONE NUMBER

**ADDITIONAL MEDICATIONS**

NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

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\_\_\_\_\_  
PARENT SIGNATURE/DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE/DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
TELEPHONE NUMBER