1) PERMISSION TO ADMINISTER EPINEPHRINE VIA PRE-FILLED AUTO-INJECTOR;
2) PERMISSION OR REFUSAL TO APPOINT DESIGNEE

1) Our child, _____, requires the administration of epinephrine in case of an anaphylactic reaction. We understand that we must submit to the School Nurse written orders from a healthcare provider, indicating that our child requires the administration of the medication. We further understand that we must provide the school with a current epinephrine pre-filled auto-injector, that we are responsible for replacing it when it has expired or been used, and that we shall pick it up at the end of the school year or the end of the period of medication. Our permission is effective for the school year for which it is granted. We understand that it must be renewed for each subsequent school year..

We understand that the School Nurse will be available during the standard school day but will not be available at school-sponsored events or after school activities in the event of an allergic reaction. The trained designee, if appointed, will be available during school hours and at school-sponsored events. We realize that it is our responsibility to inform the school nurse in a timely manner of the school-sponsored events in which our child will participate. We further understand that the designees may be assigned to student who are qualified to self-administer their emergency medications, as well as to those who are not qualified to self-administer. In the event that we decline to have a designee appointed, we also understand that there will not be a nurse at school-sponsored events occurring outside the standard school day.

Pursuant to N.J.S.A. 18A:40-12.5, we acknowledge our understanding that Deal School District, its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to our child, and we indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine to our child.

We hereby grant permission to the School Nurse or Medical Inspector to administer epinephrine via a pre-filled auto-injector mechanism, to treat our child for anaphylaxis.

_____ _____
Parent/Guardian signature Date

2) We **authorize** the School Nurse to designate and train one or more employee volunteers of the Deal Elementary School District to administer epinephrine via pre-filled auto-injector mechanism to our child in case of emergency, when the School Nurse or Medical Inspector is not present.

We understand that no other medications, such as antihistamines, may be administered by the designee, and that the epinephrine via pre-filled auto-injector mechanism will be administered by the designee according to the orders provided by our child's Healthcare Provider.

_____ _____
Parent/Guardian signature Date

We **DO NOT** authorize the School Nurse to designate one or more employees of the Deal Elementary School District to administer epinephrine via pre-filled auto-injector mechanism to our child. We understand that a nurse will not be available during school-sponsored events outside the standard school day and that 911 will be activated in the event of an allergic reaction.

_____ _____
Parent/Guardian signature Date

EMERGENCY ALLERGY ACTION PLAN & MEDICATION ADMINISTRATION FORM

Emergency Information for:

Name: _____ Grade: _____

Life-threatening allergies to: (please list **any/all** known allergens)

_____

Student has history of **documented** anaphylaxis: (circle one) **YES** **NO**
Student **is capable** of self-administration: (circle one) **YES** **NO**
Is the student **asthmatic?** **YES** **NO**

STEP 1. Determine how to treat reaction promptly.

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
If a food allergen has been ingested, but *no symptoms*: If exposed to allergen/stung, *but no symptoms*:	Epinephrine Antihistamine NO TREATMENT
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine Antihistamine NO TREATMENT
Skin: Hives, itchy rash, swelling of the face or extremities	Epinephrine Antihistamine NO TREATMENT
Gut: Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine Antihistamine NO TREATMENT
Throat:† Tightening of throat, hoarseness, hacking cough	Epinephrine Antihistamine NO TREATMENT
Lung:† Shortness of breath, repetitive coughing, wheezing	Epinephrine Antihistamine NO TREATMENT
Heart:† Weak or thready pulse, low blood pressure, fainting , pale, blueness	Epinephrine Antihistamine NO TREATMENT
Other† _____	Epinephrine Antihistamine NO TREATMENT
If reaction is progressing (several of the above areas affected), give:	Epinephrine Antihistamine NO TREATMENT

†All of the above symptoms can progress to a life-threatening reaction.

MEDICATION ORDERS AS FOLLOWS:

Epinephrine: inject intramuscularly (circle one) EpiPen®. 0.3mg Twinject® 0.3mg

Epipen .15mg

Antihistamine: (if indicated in above plan) give _____
Medication/Dose/Route

Other: give_____
Medication/Dose/Route

STEP 2. Call **911**. Inform EMS that epinephrine has been administered for an allergic reaction.

Emergency Contact Information

Mother: Emergency cell phone: (_____) _____-_____

Home telephone: (_____) _____-_____

	Work telephone:	(_____) _____-_____
Father:	Emergency cell phone:	(_____) _____-_____
	Home telephone:	(_____) _____-_____
	Work telephone:	(_____) _____-_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO A MEDICAL FACILITY!

TREATMENT PLAN FOR A DELEGATE WHEN SCHOOL NURSE NOT PRESENT:

In accordance with N.J.S.A. 18A:40-12.6, the school nurse shall designate additional employees of the school district who volunteer to administer a **onetime** dose of epinephrine to a student exhibiting signs and symptoms of anaphylaxis to serve as delegates when the nurse is not physically present at the scene. **(Please check and complete either A or B. *** BY LAW, ANTIHISTAMINES CANNOT BE GIVEN BY A DELEGATE.)**

A _____ Delegate **Order**—For symptoms of anaphylaxis listed above, delegates are to immediately administer epinephrine (circle one) Epipen 0.3mg Twinjet 0.3mg

B. _____ This student's order **SHOULD NOT** be delegated.

Doctor's Signature: _____

Date: _____

Doctor's Stamp

I request that my child be given the medication described in the manner above by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector, and if prescribed a single dose of an antihistamine, and self-medicate when necessary. If carried on his/her person, I will be aware of the expiration dates and replace when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child, or from self-administration when certified by the physician.

Parent/Guardian's Signature: _____ Date: _____

****A new form must be submitted for each school year****