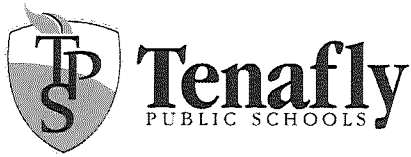


500 Tenafly Road, Tenafly, NJ 07670

Dear Parent/Guardian:

Our medication policy encourages parents to administer all medications at home; however, it is recognized that children with special needs, chronic illnesses or medical conditions and specific disabilities may require medication during the school day.

In accordance with the Board of Education POLICY AND REGULATION ON THE ADMINISTRATION OF MEDICATION, a physician's prescription and written parental consent must accompany ALL medication, both PRESCRIPTION AND NONPRESCRIPTION (over the counter).

PRESCRIPTION AND NON-PRESCRIPTION medications must be brought to.school in the original container with the original label. It will be kept locked in the health office. Under no circumstances are students permitted to keep medication with them while in school.

A written statement from the physician must be brought to school at the start of each school year for those students who are on continuous daily medication or who require "as needed" medication for allergies, allergic reactions, chronic headaches, etc.

NO MEDICATION WILL BE ADMINISTERED WITHOUT THE WRITTEN PERMISSION OF THE PARENT AND PHYSICAN.

Sincerely,

Dr. Rehan Shamim
School Physician

/ss
Medication Policy

Office of the Nurse

TENAFLY HIGH SCHOOL
19 Columbus Drive
Tenafly, NJ 07670-1698
Tel: 201-816-6670
Fax: 201-837-1035

PARENT PERMISSION FORM FOR STAFF TO ADMINISTER EPINEPHRINE OR INHALER IN THE ABSENCE OF THE SCHOOL NURSE

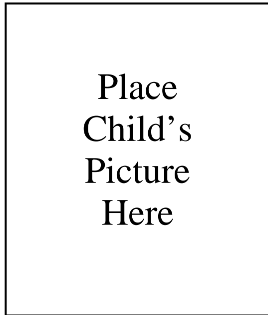
I give my permission to have a teacher or other staff member of the Tenafly School District administer Epinephrine or inhaler to my child in the event of any emergency in which a school nurse is not available. You may release any appropriate information to staff involved with my child.

STUDENT NAME ____

____
PARENT/GUARDIAN SIGNATURE

____
DATE

Food Allergy Action Plan



Student's Name:_______________________________ **D.O.B:**____________ **Teacher:**______________________

ALLERGY TO:____

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

◆ STEP 1: TREATMENT ◆

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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: ______________________) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _________________________________ at _________________________________

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. ________________________________	1.)______________________	2.) ____________________
b. ________________________________	1.)______________________	2.) ____________________
c. ________________________________	1.)______________________	2.) ____________________

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

Parent/Guardian Signature____ Date______________

Doctor's Signature____ Date______________
(Required)

DOCUMENTATION OF AN ANAPHYLACTIC INCIDENT

The new law (NJSA 18A: 40-12.5) mandates that the use of an Epi Pen as a first treatment must be based on previously documented anaphylactic incident.

Student's Name ____________________ **DOB** __________ **Grade** ______

Reviewed By ____________________ RN **School** __________

TO BE COMPLETED BY PHYSICIAN

____________________ has had an anaphylactic incident:

☐ from a sting by ____________________ Date __________
☐ after ingesting ____________________ Date __________
☐ after exposure to ____________________ Date __________

SYMPTOMS of the student's anaphylactic reaction included:

☐ hives spreading over the body
☐ wheezing
☐ difficulty swallowing / breathing
☐ swelling of lips, face, or neck
☐ tingling and swelling of tongue
☐ nausea / vomiting
☐ signs of shock (extreme pallor of flushing; clammy skin; rapid, weak pulse)
☐ loss of consciousness
☐ Other

____
____

MEDICATION given at the time of the incident:

☐ Epi Pen ☐ Epi Pen Jr. ☐ other form of adrenaline: __________

____

☐ Epi Pen has been prescribed for precautionary purposes.

COMMENTS

____
____

Physician ____________________

Date ____________________ **Telephone** __________

I. DOCTOR'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE.
TO BE FILLED OUT BY PHYSICIAN

The following medication is to be administered to my patient. ______________________________________

MEDICATION ____________________________ DOSE AND ROUTE ____________________________

TIME GIVEN _____________________________ DIAGNOSIS __________________________________

SIGNIFICANT SIDE EFFECTS ____

LENGTH OF TREATMENT ________________ ____________________________________

M.D. Signature

____

Print M.D. Name

II. DOCTOR'S REQUEST / INSTRUCTIONS FOR STUDENT SELF-ADMINISTRATION OF MEDICATION FOR A POTENTIALLY LIFE THREATENING ILLNESS.

TO BE FILLED OUT BY PHYSICIAN

The following medication is to be self-administered by my patient, __________________________________.
I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been Instructed in the proper administration of the required medication.

MEDICATION ______________________________ DOSE AND ROUTE __________________________

TIME GIVEN _______________________________ DIAGNOSIS _________________________________

LENGTH OF TREATMENT __________________

SIGNIFICANT SIDE EFFECTS ____

___________________________ ____________________________________

Date M.D. Signature

____

Print M.D. Name

III. PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN

I request my child, __________________________ to (receive) (self-administer) the medication designated above. I have been informed by the school district that the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the **TENAFLY BOARD OF EDUCATION,** its agents, servants, and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medicine by my child.

___________________________________ ____

Date Signature of Parent/Guardian