MERCER COUNTY TECHNICAL SCHOOLS

Anaphylaxis Individual Emergency Care Plan

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student'sName:_____ **Date of Birth:**_____

I request that my child be permitted to self-medicate as authorized by me and my child's physician. I understand that this authorization is effective only for the present school year and must be renewed for each subsequent year. I understand that Mercer County School District shall incur no liability as a result of any injury arising from the self-medication and that I hold harmless the district and its employees against any claims arising out of the self-administration of medication. I agree to indemnify and hold harmless the district and their employees or agents against any claims arising out of the self-administration of medication. ***I understand that before my child will be permitted to self-administer medication, I must provide the school nurse with an epi-pen that my child will be carrying and self-administrating. I understand that I am responsible for collecting the emergency medication at the end of the school year and should I not collect the medication it will be properly disposed.***

Parent/Guardian Signature:_____**Date:**_____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Allergy to:_____

This reaction ___**could /**__ **could not** be described as anaphylactic. Presenting symptoms include:

Please check off the appropriate symptoms:

__ Skin: "hives" (red blotches or welts which itch): severe swelling
__ Eyes: tearing, redness, itching
__ Lungs: shortness of breath, rapid breathing, cough, wheeze
__ Gut: repeated vomiting, nausea, abdominal pain (diarrhea later)
__ Brain: anxiety, agitation, or loss of consciousness
__Throat: tightness, trouble speaking, and trouble breathing
__Nose: running, itching, congested
__Mouth: itching, swelling of lips, tongue, or mouth
__Heart/Circulation: weak pulse, loss of consciousness

In the event of an allergic reaction, the school nurse should proceed as follows:

1. If the child develops only hives (only skin problems) give antihistamine.
    a. Dose: **Benadryl _____mg** by mouth
    Oral antihistamine must be given only by nurse or parent.
    b. Observe closely for additional symptoms; notify parent/guardian

2. If the child develops any of the signs of severe reaction of anaphylaxis,
    a. Inject **Epinephrine IM: Dose ___.15mg -___.30mg**
    b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms recur.
    c. Give the above dose of Benadryl by mouth
    d. Notify parent/guardian, and call 911

3. If wheezing occurs, treat with:_____

In the event of an allergic reaction when the school nurse is unavailable (field trips and/or school related activities)

____ **Able to self medicate** – I give my permission for this child to self-medicate when the school nurse is not available. I certify that _____ (student name) is capable of and has been instructed in the proper method of self-administrating his/her medication including self assessment of symptoms and indications for administration. In the event that my child cannot self-medicate, I give my permission for a trained delegate to administer a single dose of an Epi-pen and call 911.

____ **Unable to self medicate** – This child is not able to self medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a trained delegate to administer a single dose of an Epi-pen and call 911**. I understand that the delegate is not permitted by NJ State law to give Benadryl.**

_____ _____

Physician's signature **Date** **Office Stamp**