PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT (20_-20____)

Date Given to Parent/Guardian _____ Date returned _____

Student's name _____ DOB _____ Grade _____

The above student is allergic to: _____

Previous episode of anaphylaxis ☐ Yes ☐ No Asthmatic ☐ Yes ☐ No

MEDICATIONS

ANTIHISTAMINE: _____

MEDICATION/DOSE/ROUTE

_____

MEDICATION/DOSE/ROUTE

EPINEPHRINE: ☐ EpiPen (0.3mg) ☐ EpiPen Jr. (0.15mg) ☐ Other _____

☐ Twinject (0.3mg) ☐ Twinject (0.15mg)

Repeat dose in _____ minutes

		Give Checked Medication	
CONTACT	Contact only with allergen(s) _____ but with no symptoms	( ) Epinephrine	( ) Antihistamine
SKIN	Hives, itchy rash, swelling of face or extremities	( ) Epinephrine	( ) Antihistamine
MOUTH	Itching, tingling, burning, or swelling of lips, tongue, and mouth	( ) Epinephrine	( ) Antihistamine
THROAT	Tightening of throat, hoarseness, hacking cough	( ) Epinephrine	( ) Antihistamine
GUT	Abdominal cramps, nausea, vomiting, diarrhea	( ) Epinephrine	( ) Antihistamine
LUNGS	Repetitive cough, wheezing, shortness of breath	( ) Epinephrine	( ) Antihistamine
HEART	Thready pulse, low blood pressure, fainting, pale, or bluish skin	( ) Epinephrine	( ) Antihistamine
GENERAL	Panic, sudden fatigue, chills, fear of impending doom	( ) Epinephrine	( ) Antihistamine
OTHER		( ) Epinephrine	( ) Antihistamine

MEDICATION ADMINISTRATION ORDER:

CHOOSE ONE

☐ Give Epinephrine only *(Delegate will be assigned)

☐ Give Antihistamine & Epinephrine at same time *(Delegate will be assigned)

☐ Give Antihistamine first, observe for further symptoms and give Epinephrine PRN

***Please note – in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

☐ This student has been trained and is capable of self-administration of the following medication(s) named above

☐ Epinephrine – single dose auto-injector

☐ Epinephrine & Antihistamine – single dose auto injector & premeasured dose of antihistamine

☐ This student is not capable of self-administration of the medications named above

*Under NJ State Law, orders for antihistamine alone cannot be self administered

Physician's signature _____ Date _____

Address _____ Telephone _____

Physician's Stamp

School Doctor's signature _____ Date _____

Parent signature _____ Date _____

Parents/Guardians

The prescribed antihistamines and Epinephrine auto-injector(s) must be provided to the school nurse by the parent/guardian, and all medications must be provided in the original pharmacy container.
Permission for the self-administration of prescribed medication is effective for the school year for which it is granted and must be renewed for each subsequent school year.

Select one to sign and date

1. I verify that my child _____ has a potentially life-threatening illness and has been instructed in self-administration of the prescribed medication in a life-threatening situation. I hereby give permission for my child to self-administer prescribed medication. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____

Parent/Guardian Signature Date

2. I verify that my child _____ has a potentially life-threatening illness and is unable to self-administer the prescribed medication in a life-threatening situation. I hereby request the school nurse to delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from administration of the medication to my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of administration of medication to my child.

_____ _____

Parent/Guardian Signature Date

Please sign

I understand that under NJ State law, a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded, and epinephrine will be administered by a trained delegate.

_____ _____

Parent/Guardian Signature Date

SCHOOL USE ONLY

_____ _____

Signature of School Nurse Date

NOT CAPABLE OF SELF-ADMINISTRATION

PATERSON PUBLIC SCHOOLS
AUTHORIZATION FOR EMERGENCY ADMINISTATION OF MEDICATION
(EPINEPHRINE AUTO-INJECTOR)
FOR POTENTIALLY LIFE-THREATENING ILLNESS
(P.L. 2007 C.57)

Student Name _____ **School** _____

Date _____ **Grade** _____

Medication _____ **Dosage** _____

Purpose _____

Diagnosis _____

I hereby give written authorization for the administration of the above listed medication and dosage in case of emergency since student does not have the capability for self-administration

ATTACH PHYSICIAN'S ORDER:

Private Physician Name _____ Telephone _____

Private Physician Signature _____

****

I, _____ the parent/guardian of _____
(Print Parent/Guardian Name) (Print Student Name)

Give my permission for this medication to be administered. I understand that I will provide the school with the Epinephrine Auto-Injector as prescribed by the private physician, properly packed and labeled by the pharmacy, and I will update the Epinephrine Auto-Injector according to the expiration date.

I understand that the Paterson Public School District and its employees or agents shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism.

Parent/Guardian Name _____ Date _____
(Print)

Parent/Guardian Signature _____ Date _____

Emergency Contact Name _____ Emergency Contact Telephone Number _____
(Print)

School Physician's Signature _____ Date _____

NOTE: PERMISSION MUST BE RENEWED FOR EACH SUBSEQUENT SCHOOL YEAR

Paterson Public Schools
New Roberto Clemente/Newcomers @ NRC
482-506 Market Street, Paterson, NJ 07501
School Health Office
Telephone: 973-321-0249
Fax: 973-321-0247

Grade _____ Homeroom # _____

Student Name: _____

Mother's Name: _____

Father's Name: _____

Address: _____

City: _____

Home Phone #: _____

Mother Cell # _____

Father Cell #: _____

Parent Signature: _____

Emergency contact numbers to follow:

1. Name: _____
   Relation: _____
   Emergency #: _____

2. Name: _____
   Relation: _____
   Emergency #: _____

3. Name: _____
   Relation: _____
   Emergency #: _____

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

Date: _____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

To Whom It May Concern:

This is to certify that I, _____, the parent/legal guardian of _____ Grade _____, do hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning _____ DOB _____.

Please send records to the attention of the School Nurse at:

School Name and Address _____

_____

_____

Signature of Parent or Guardian: _____

Signature of School Nurse: _____ Telephone: 973-321-_____

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

Date: _____

Name and Address of School Nurse and Public School:

_____

_____

_____

To Whom It May Concern:

This is to certify that I, _____, the parent/legal guardian of _____ Grade _____, do hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning _____ DOB _____.

Please send records to the attention of the Hospital or Health Care Provider at:

Health Care Provider Address _____

_____

_____

Signature of Parent or Guardian: _____

Signature of Healthcare Provider: _____ Telephone: _____

Signature of School Nurse: _____ Telephone: 973-321-_____

INDIVIDUALIZED HEALTHCARE PLAN (IHP)
SEVERE ALLERGIES

STUDENT NAME:_____ **DOB**_____

Student Address:
Home Phone:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Provider Phone:
IHP Written By:

School:
Teacher/Counselor:
Grade:
IHP Date:
IEP Date:
Review Date(s):
ICD-9 Codes:

Parental/Guardian statement: ***I/We have read this plan and agree to its implementation.***
Signature:_____ **Date:** _____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes
	Ineffective breathing pattern related to: _ bronchospasm _ inflammation of airways	The student will identify symptoms of allergic reaction. The student will participate in development and implementation of healthcare plans at school. The student will be safe in all school environments.	Provide necessary health counseling opportunities for student to participate in self-care (depending on the student's cognitive and/or physical ability). -Review symptoms and sources of allergen(s). - Review treatment methods, including how/when to report allergic symptoms to school personnel. - Teach proper technique of self-administration of epinephrine. - Continuously monitor school environment for potential allergens.	The student will identify his or her symptoms of an allergic reaction (from mild to severe) and share information with appropriate school personnel. The student will actively participate in healthcare management and ICP at school.

Individualized Health Care Plan

STUDENT NAME: _____ **DOB** _____

Parental/Guardian Statement: ***I/We have read this plan and agree to its implementation.***

Signature:_____**Date:** _____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes
	Effective therapeutic regimen management related to: - ability to seek help from others - ability to self-medicate when appropriate	The student will be safe in all school environments. The student will develop self-medication skills when appropriate. The student will prevent allergic reactions from occurring.	Provide in-service for school staff (including school bus driver, if appropriate) about allergic reaction/anaphylaxis. - Identify student's known food or insect allergen(s). - Discuss symptoms of mild to severe allergic reactions, including anaphylaxis. - Develop specific guidelines for treatment (from mild to severe) - ECP. - Document each episode of allergic reaction. - Request that classroom teacher alert room mothers about food allergy and need for alternative party treats. - Make field trip modifications as needed (e.g., medication must be taken along on all field trips). - Make extracurricular activities (e.g., dances, carnivals) modifications that are needed. - Continuously monitor school environment for potential allergens.	The student will describe steps to take if an allergic reaction occurs. The student will inform school personnel when treatment for an allergic reaction is necessary. The student will actively participate in healthcare management and ECP at school. The student will identify school personnel responsible for helping carry out the healthcare management and ECP.

Paterson Public School # _____ School Year _____

Emergency Care Plan for Anaphylaxis: Severe Allergic Reaction

Keep this Plan in your Emergency and Sub folders

Student: _____ DOB _____ Grade _____ Student ID _____

Parent/Guardian _____ Address _____ Phone _____

Alternate Parent _____ Phone _____

Doctor _____ Phone _____

School MD _____ Plan written by _____

Severe allergic reaction to _____

___ This student is approved to self-administer (circle): Epi-pen _____mg or Epinephrine auto injector ____mg

___ This student is NOT approved to self-administer medication and requires a delegate to administer the following: (circle) Epi-pen _____mg or Epinephrine auto injector _____mg

Location of medication (unlocked area): _____

Persons authorized to administer treatment: School Nurse: _____

_____ Student _____ Delegate(s) _____

Signs of Emergency: swollen lips, hives, swelling, difficulty breathing, cyanosis, hypotension, shock, feeling of impending doom (see orders for additional information).

Treatment for Severe Allergic Reaction:

1. Call 911; inform them that the student is having an allergic reaction to _____
2. Call nurse or delegate _____ who will follow MD orders
3. If student is able to self-administer, stay with student, call 911 and the Nurse
4. Nurse will complete documentation of the incident on student health file
5. Emergency personnel will transport student to the nearest emergency room, give the used epinephrine auto injector to the EMS
6. In case of an evacuation, the student will evacuate with the teacher to the new location

Teachers: Please see the Nurse so that you may be trained as an epinephrine auto injector delegate; each student with an auto injector must have a delegate on a field trip. Thank you!