MIDDLESEX REGIONAL EDUCATIONAL SERVICES COMMISSION

Emergency Health Plan for Anaphylaxis
Student/Parent Instructions

The Emergency Health Plan for Anaphylaxis is designed to help facilitate and coordinate the care of an individual student to achieve the goal of rapid and appropriate treatment of an anaphylactic reaction.

1. Students/Parents/Guardians: *Before taking this form to your Health Care Provider:* Complete the top of the form with:
    - Student's name
    - Student's date of birth
    - Student's doctor's name and phone number
    - Parent/Guardian's name and phone number

2. Your Health Care Provider will:
   Complete the following areas:
    - The effective date of this plan
    - The medicine information for the Caution and Emergency sections
    - Your Health Care Provider will check the boxes next to the medications and check the boxes for how much and when to administer/take them
    - Your Health Care Provider may check "OTHER" and write in antihistamine medications that are not listed on the form

3. Students/Parents/Guardians and Health Care Providers together:
   Discuss and then complete the following areas:
    - Student's Allergen List
    - **For Minors Only** section at the bottom of the form – Discuss the student's ability to carry and/or self-administer the Epinephrine Auto-Injector, check the appropriate box, designate your Hospital preference (which will be honored if possible at the discretion of the EMS/Paramedics at that time) and then both you and your Health Care Provider must sign and date the form.

4. The School Nurse will designate and train the appropriate School Staff as Delegates for the Emergency Administration of the Epinephrine Auto-Injector when the School Nurse is not physically present in accordance with New Jersey State Law.

5. Parents/Guardians: *After completing the form with your Health Care Provider will:*
    - Give the signed original form to the School Nurse
    - Provide the *labeled* medications as ordered by your Health Care Provider *in their original containers* to your School Nurse

INDIVIDUAL EMERGENCY HEALTH PLAN FOR ANAPHYLAXIS for ____/____ School Year

(Anaphylaxis is a potentially life-threatening allergic reaction. Act quickly.)

Name:______________________________ Date of Birth:__________

Doctor:______________________________ Parent/Guardian:______________________

Phone:______________________________ Phone:______________________

DELEGATES TRAINED IN THE USE OF EPINEPHRINE AUTO-INJECTORS:

______________________________ ______________________________

☐ **Asthmatic** (Check if YES - Student has higher risk of a severe allergic reaction. Epinephrine should be given first (before asthma medications) in case of a reaction with any breathing symptoms.

ALLERGEN(S):____

Medications & Dosages: **Child's Weight:_____lbs.**

☐ **Epinephrine Auto-Injector**, Jr. 0.15 mg intramuscularly prn anaphylaxis & call 911. May repeat once as indicated below if symptoms do not improve within 20 minutes of 1st dose or return of symptoms.

☐ **Epinephrine Auto-Injector** 0.3 mg intramuscularly prn anaphylaxis & call 911. May repeat once as indicated below if symptoms do not improve within 20 minutes of 1st dose or return of symptoms.

☐ **Benadryl** ____mg. po q 4-6 hrs prn allergic reaction.

OR

☐ **Other antihistamine:**__________________ ____mg. po q___ hrs prn allergic reaction.

CAUTION	Epinephrine	Epinephrine 2nd Dose	Antihistamine
No symptoms and *suspected* ingestion of allergen	☐	☐	☐
No symptoms and *known* ingestion of allergen	☐	☐	☐
Nose/Eyes: Hayfever-like symptoms: runny, itchy Nose, red eyes	☐	☐	☐
Skin (1): Localized hives and/or localized itchy rash	☐	☐	☐

EMERGENCY	Epinephrine	Epinephrine 2nd Dose	Antihistamine
Mouth: Itching, tingling or swelling of lips, tongue or mouth	☐	☐	☐
Skin (2): Hives and/or itchy rash on more than one part of the Body, swelling of face or extremities	☐	☐	☐
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐	☐	☐
Throat: Hacking cough, tightening of throat,hoarseness, Difficulty swallowing	☐	☐	☐
Lung: Shortness of breath, wheezing, short, frequent, Shallow cough	☐	☐	☐
Heart: Weak pulse, low blood pressure, fainting, dizzy, Pale, cyanotic (blueness)	☐	☐	☐
Multiple: Symptoms from 2 or more of the above categories	☐	☐	☐

For Minors Only:

☐ **This student is capable and has been instructed in the proper method of self-administration of the Epinephrine Auto-injector in accordance with New Jersey Law.**

☐ **This student is NOT approved to self-medicate.**

☐ **This student MAY CARRY the Epinephrine Auto-injector.**

☐ **This student MAY NOT CARRY the Epinephrine Auto-injector.**

______________School, Middlesex Regional Educational Services Commission, the Diocese of Metuchen (where applicable) and their employees/agents are not liable for any complications arising from the administration of the Epinephrine Auto-injector or other medication.

This student is my patient and I have ordered the above treatment plan.

____

Physician Signature & Stamp (Below) Date

I authorize the administration of above for my child, to be followed by transportation to __________ (or nearest) Hospital if Epinephrine is given.

____

Parent/Guardian Signature Date