LENAPE REGIONAL HIGH SCHOOL DISTRICT

CHEROKEE	LENAPE	SENECA	SEQUOIA	SHAWNEE
856-983-5140 Fax: 856-810-4379 (grades 9 & 10) Fax: 856-810-4378 (grades 11 & 12)	609-654-5111 Fax: 609-714-7808	609-268-4600 Fax: 609-268-4389	609-268-3700 Fax: 609-268-3726	609-654-7544 Fax: 609-654-5611

PHYSICIAN'S AUTHORIZATION FOR SELF-ADMINISTRATION OF EPINEPHRINE BY PUPIL

STUDENT NAME _____ GRADE _____

The above individual is a pupil in your school district and is under my medical care for a potentially life-threatening allergy. Allergens include: _____

Previous episode of anaphylaxis? YES NO (Please circle)

Symptoms_____

Legislation allows the parents/guardians of a pupil who has a life-threatening allergy to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to the school district that the pupil has been instructed in and is capable of the proper self-administration of medication.

The above named student has been instructed in and is capable of self-administration of the medication(s): **Please check off the appropriate medication(s) and dose:**

☐ Benadryl, _____mg

☐ Epinephrine auto-injector

for the treatment of _____ allergy for the school year.

In the absence of a school nurse, a trained delegate will administer epinephrine auto-injector.

In the event that the medication that I have prescribed is changed in the future, or if the student is not capable of self-administration of the prescribed medication, I will notify the school district.

PHYSICIAN'S STAMP/PRINTED NAME_____ PHONE # _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PARENT'S CONSENT FOR SELF-ADMINISTRATION OF EPINEPHRINE BY STUDENT

I/We are aware that legislation allows students to self-administer medication in the treatment of life-threatening allergies as long as the physician certifies that the student has been instructed in, and is capable of self-administering the prescribed medicine.

I/We acknowledge that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and we agree to indemnify and hold harmless the school district and its employees or agents against any claims arising out of the self-administration of medication by the pupil.

I/We authorize the student _____ to self-administer Benadryl by mouth and/or epinephrine auto-injector for the treatment of his/her allergic reaction for the school year.

I/We understand that in the absence of a school nurse, a trained delegate will administer epinephrine auto-injector. Neither the school nurse nor the delegate shall incur any liability as a result of any injury arising from administration of medication to the student. I/We give permission for relevant health information to be shared with teachers/staff/delegate.

PARENT'S/GUARDIAN'S PRINTED NAME _____ PHONE #_____

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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This information should not take the place of talking with your child's doctor.