

Dear Parent/Guardian,

Your student's health record indicates that he/she has a history of **anaphylaxis** that requires use of an **Epinephrine Auto-Injector**.

**In order to participate in the athletic program, school-sponsored activities and field trips, the following must be completed and submitted to the School Nurse at the start of EACH school year :**

1. **All enclosed paperwork** in this packet must be completed by physician and parent/guardian.
2. **An Epinephrine Auto-Injector** to be kept on your child at all times (with an approval to self administer form filled out by the physician and parent/guardian if applicable).

**\*All forms must be dated after July 1st for the applicable school year.**

**Transportation:** You must advise the transportation department at your **home school district** that your child has anaphylaxis.

**No longer has anaphylactic allergies:** Provide a note from your child's physician stating he/she no longer has life-threatening allergies that require Epinephrine.

**12th grade students attending CCM/other colleges:** These forms are required to be completed and submitted to the health office if your child plans to participate in MCST clubs, athletic teams and school sponsored events and trips

We welcome the opportunity to meet with you and your child to discuss any concerns you may have.

Sincerely,

Ms. Carol Maffei, RN

Ms. Rebecca Reinfeld, RN

School Nurses



**FARE**  
Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s)** \_\_\_\_\_.

**Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.**

## For ANY of the following SEVERE SYMPTOMS



### LUNG

Shortness of breath, wheezing, repetitive cough



### HEART

Pale or bluish skin, faintness, weak pulse, dizziness



### THROAT

Tight or hoarse throat, trouble breathing or swallowing



### MOUTH

Significant swelling of the tongue or lips



### SKIN

Many hives over body, widespread redness



### GUT

Repetitive vomiting, severe diarrhea



### OTHER

Feeling something bad is about to happen, anxiety, confusion

### OR A COMBINATION

of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

## MILD SYMPTOMS



### NOSE

Itchy or runny nose, sneezing



### MOUTH

Itchy mouth



### SKIN

A few hives, mild itch



### GUT

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE BODY SYSTEM, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE BODY SYSTEM (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

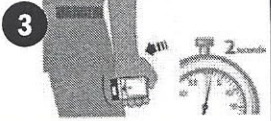


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# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

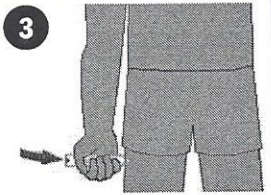
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



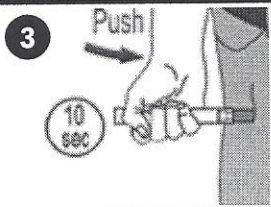
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



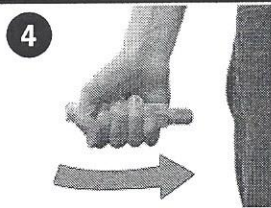
## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



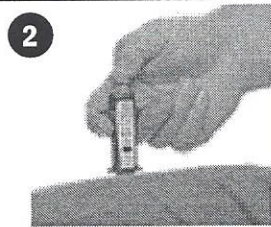
## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

**Epinephrine first, then call 911.** Monitor the patient and call their emergency contacts right away.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_  
DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

Name of Student:

Grade:

Diagnosis:

Medication: Epi Pen

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**Section 1: To Be Completed by the Physician: Morris County School of Technology Physician Certification for Self Medication N.J.S.A 18A:40-12.3**

I certify that the above name student has the above medical condition which is a potentially life threatening illness. I have discussed the administration of this medication with the above student, and certified that he/she is capable of, and has been instructed, in the proper method of self administration of the medication in an emergency situation as directed above.

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Physician's Signature

Date

**Section 2: To be Completed by the Parent/Guardian: Parent Acknowledgement and Authorization Pursuant to N.J. S.A 18A: 40 - 12.3**

- A. **I hereby authorize my child to carry his/her own medication during school, on field trips, and during school sponsored extracurricular activities.** My child has been instructed on self administration of the medication in potentially life threatening situations as evidenced by my submission of the above Physician Certification. I also understand that I am responsible for providing the medication and am responsible for replacing it if it is expired or used. By also signing the acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability as a results of any arising from the self administration or medication of the student; and I hereby indemnify and hold harmless the board and its offices, employees and agents against any claims arising out of the self administration by the student. This permission is effective the current school year only and will be reviewed each subsequent year if the medication needs to be continued. **Yes** \_\_\_ / **No:** \_\_\_

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Parent/ Guardian Signature

Date

- B. **Parent Authorization for administration of epinephrine by delegates.** I give consent for the administration of epinephrine via pre-filled auto injector by the district delegate training by the certified school nurse to administer epinephrine in the event that the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees. **Yes** \_\_\_ / **No:** \_\_\_

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Parent/ Guardian Signature

Date

- C. I give permission for the school nurse to release my child's health concerns as indicated above, to the staff at MCVTS. The school nurse may have indicated this health concern in the genesis program.

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Parent/ Guardian Signature

Date

Name of Student:

Grade:

Diagnosis:

Medication: Epi-Pen

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**Section 3: To be Completed by the MCST Student:** Student Acknowledgement Pursuant to N.J. S.A  
18A:40-12.3.

- I understand and I will use this medication as directed by my physician.
- I will be responsible for carrying and using this medication as described while in school, on field trips, athletic events and at any other school sponsored event.
- I understand to keep the supplies for self-management with me at all times and that all medication mentioned in the prescribed self-management plan must be in its original labeled container, at all times.
- I am aware that I must report to the school nurse or delegate if there are any deviations from the parameters set in the self-management plan.

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Student Signature

Date