Matawan Aberdeen Regional School District

Physician's Order for the Administration of Epinephrine

Student's Name:_______________________________ **DOB**:_____________
School: _______________________________________ **Grade/Rm**: ________

I CERTIFY THAT THE ABOVE NAMED STUDENT IS ALLERGIC TO:
____

Exposure to these allergens in the past: _____ **HAS** resulted in ANAPHYLAXIS
_____ **HAS NOT** resulted in ANAPHYLAXIS

Asthma: _____ Yes (high risk for severe reaction) _____ No

Symptoms of Anaphylaxis

MOUTH itching, swelling of lips and/or tongue
THROAT* itching, tightness/closure, hoarseness
SKIN itching, hives, redness, swelling
GUT vomiting, diarrhea, cramps
LUNG* shortness of breath, cough, wheeze
HEART* weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
***Some symptoms can be life-threatening. ACT FAST!**

EPINEPHRINE: Specify medication: ____
Dose: _______ **(0.15 mg)** _______**(0.3 mg)**

ANTIHISTAMINE:Specify Medication/Dose: ___________________________________

_________ Student has been trained in procedure and may carry and self administer epinephrine auto injector and antihistamine according to N.J.S.A. 18A:40-12.3.

_________ Antihistamine (if prescribed) may be OMITTED from the above plan on a field trip when a nurse or parent does not attend the trip and when the student is not certified to self administer. *In accordance with N.J.S.A. 18A:40-12.6, a designee of the school nurse who has been properly trained in the administration of epinephrine will attend all field trips when the nurse or parent/guardian does not attend.*

Physician's Office Stamp

Physician's Signature: _________________________________
Date:_____________

Please see the other side for more information.

PARENT/GUARDIAN CONSENT TO ADMINISTER MEDICATION FOR ANAPHYLAXIS

School Nurse:
I hereby request that the school nurse administer the medication specified on page 1 of this form as directed by my physician to my child________________________________.
I will supply the medication in the ORIGINAL CONTAINER and will promptly notify the school nurse of any changes in this order.

___________ ____
DATE SIGNATURE OF PARENT/GUARDIAN

Self-Administration of Medication:
I verify that my child has my permission to self-administer the medication specified on page 1 of this form. (CERTIFICATION MUST BE PROVIDED FROM STUDENT'S PHYSICIAN ACKNOWLEDGING STUDENT HAS BEEN INSTRUCTED IN THE PROPER METHOD OF SELF-ADMINISTRATION OF MEDICATION)

____________ ____
DATE SIGNATURE OF PARENT/GUARDIAN

Designee of School Nurse:
This is to verify that the designees of the school nurse, who have been properly trained in the administration of the medication for anaphylaxis, have my permission to administer said medication to my child.

_____________ ____
DATE SIGNATURE OF PARENT/GUARDIAN

Waiver of Liability (waiver must be signed by parent/guardian in order for administration of medication by nurse, designee or self-administration by pupil)
I agree that if the procedures specified in School Board Policies and Regulations 5141.21 and 5141.21R, regarding administration of medication are followed, the school district and its employees or agents shall incur no liability as a result of any injury.

______________ _______________________________________
DATE SIGNATURE OF PARENT/GUARDIAN