Freehold Regional High School District

1) PERMISSION TO ADMINISTER EPINEPHRINE VIA PRE-FILLED AUTO-INJECTOR;
2) PERMISSION OR REFUSAL TO APPOINT DESIGNEE

1) Our child, _____, requires the administration of epinephrine in case of an anaphylactic reaction. We understand that we must submit to the School Nurse written orders from a healthcare provider, indicating that our child requires the administration of the medication. We further understand that we must provide the school with a current epinephrine pre-filled auto-injector, that we are responsible for replacing it when it has expired or been used, and that we shall pick it up at the end of the school year or the end of the period of medication. Our permission is effective for the school year for which it is granted. We understand that it must be renewed for each subsequent school year..

We understand that the School Nurse will be available during the standard school day but will not be available at school-sponsored events or after school activities in the event of an allergic reaction. The trained designee, if appointed, will be available during school hours and at school-sponsored events. We realize that it is our responsibility to inform the school nurse in a timely manner of the school-sponsored events in which our child will participate. We further understand that the designees may be assigned to students who are qualified to self-administer their emergency medications, as well as to those who are not qualified to self-administer. In the event that we decline to have a designee appointed, we also understand that there will not be a nurse at school-sponsored events occurring outside the standard school day.

Pursuant to N.J.S.A. 18A:40-12.5, we acknowledge our understanding that Freehold Regional High School District, its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to our child, and we indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine to our child.

We hereby grant permission to the School Nurse or Medical Inspector to administer epinephrine via a pre-filled auto-injector mechanism, to treat our child for anaphylaxis.

_____ _____
Parent/Guardian signature Date

2) We **authorize** the School Nurse to designate and train one or more employee volunteers of the Freehold Regional High School District to administer epinephrine via pre-filled auto-injector mechanism to our child in case of emergency, when the School Nurse or Medical Inspector is not present.

We understand that no other medications, such as antihistamines, may be administered by the designee, and that the epinephrine via pre-filled auto-injector mechanism will be administered by the designee according to the orders provided by our child's Healthcare Provider.

_____ _____
Parent/Guardian signature Date

We **DO NOT** authorize the School Nurse to designate one or more employees of the Freehold Regional High School District to administer epinephrine via pre-filled auto-injector mechanism to our child. We understand that a nurse will not be available during school-sponsored events outside the standard school day and that 911 will be activated in the event of an allergic reaction.

_____ _____
Parent/Guardian signature Date

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
EMERGENCY ALLERGY ACTION PLAN & MEDICATION ADMINISTRATION FORM

Emergency Information for:

Name: _____ Grade: _____

Life-threatening allergies to: (please list **any/all** known allergens)

_____

Student has history of **documented** anaphylaxis: (circle one) **YES** **NO**
Student **is capable** of self-administration: (circle one) **YES** **NO**
Is the student **asthmatic?** **YES** **NO**

STEP 1. Determine how to treat reactions promptly.

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
□ If a food allergen has been ingested, but *no symptoms*: If exposed to allergen/stung, *but no symptoms*:	□Epinephrine □Antihistamine □NO TREATMENT
□ Mouth: Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine □Antihistamine □NO TREATMENT
□ Skin: Hives, itchy rash, swelling of the face or extremities	□Epinephrine □Antihistamine □NO TREATMENT
□ Gut: Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine □Antihistamine □ NO TREATMENT
□ Throat:† Tightening of throat, hoarseness, hacking cough	□Epinephrine □Antihistamine □ NO TREATMENT
□ Lung:† Shortness of breath, repetitive coughing, wheezing	□Epinephrine □Antihistamine □ NO TREATMENT
□ Heart:† Weak or thready pulse, low blood pressure, fainting , pale, blueness	□Epinephrine □Antihistamine □ NO TREATMENT
□ Other† _____	□Epinephrine □Antihistamine □ NO TREATMENT
□ If reaction is progressing (several of the above areas affected), give:	□Epinephrine □Antihistamine □ NO TREATMENT

†All of the above symptoms can progress to a life-threatening reaction.

MEDICATION ORDERS AS FOLLOWS:

Epinephrine: inject intramuscularly (circle one) EpiPen®. 0.3mg Twinject® 0.3mg

Antihistamine: (if indicated in above plan) give _____
Medication/Dose/Route

Other: give_____

Medication/Dose/Route

STEP 2. Call **911**. Inform EMS that epinephrine has been administered for an allergic reaction.

Emergency Contact Information

Mother:	Emergency cell phone:	(_____) _____-_____
	Home telephone:	(_____) _____-_____
	Work telephone:	(_____) _____-_____
Father:	Emergency cell phone:	(_____) _____-_____
	Home telephone:	(_____) _____-_____
	Work telephone:	(_____) _____-_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO A MEDICAL FACILITY!

TREATMENT PLAN FOR A DELEGATE WHEN SCHOOL NURSE NOT PRESENT:

In accordance with N.J.S.A. 18A:40-12.6, the school nurse shall designate additional employees of the school district who volunteer to administer a **one time** dose of epinephrine to a student exhibiting signs and symptoms of anaphylaxis to serve as delegates when the nurse is not physically present at the scene. **(Please check and complete either A or B. *** BY LAW, ANTIHISTAMINES CANNOT BE GIVEN BY A DELEGATE.)**

A _____ Delegate **Order**—For symptoms of anaphylaxis listed above, delegates are to immediately administer epinephrine (circle one) Epipen 0.3mg Twinjet 0.3mg

B. _____ This student's order **SHOULD NOT** be delegated.

Doctor's Signature: _____

Date: _____

Doctor's Stamp

I request that my child be given the medication described in the manner above by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector, and if prescribed a single dose of an antihistamine, and self-medicate when necessary. If carried on his/her person, I will be aware of the expiration dates and replace when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child, or from self-administration when certified by the physician. Complete form below if requesting to self-medicate.

Parent/Guardian's Signature: _____ Date: _____

******A new form must be submitted for each school year******

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT

REQUEST FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student Name: _____ School: _____Grade: _____

Date of Birth: _____ Age: _____ ID#: _____

As per Board Policy and Regulation 5330, self-administration of medication by a student may be permitted for the treatment of asthma or other potentially life threatening illness, or a life threatening allergic reaction. A life threatening illness is defined as an illness or condition that requires an immediate response to specific symptoms and/or an after effect of disease or injury that if left untreated may lead to potential loss of life. All requests for self administration of medication are effective for one school year only and expire as of July 1st of each year.

****

SECTION ONE: To be completed by student's Private Physician

I certify that the student named above has a qualifying condition or illness that may require medication. I certify that the student has been instructed and is proficient in the proper method of self-administration of the prescribed medication, and is capable of self-carrying and self administration of the prescribed medication. I hereby request that the above named student be allowed to self-administer the following medication as prescribed by me:

Name of Medication: _____ Form of medication: _____

Diagnosis/Reason: _____ Purpose of medication: _____

Dosage: _____ Frequency: _____

Time Medication to be Self-Administered:_____

Special Instructions: _____

_____

Possible Side Effects: _____

_____

Date to Begin: _____ Date to Conclude:_____

_____ _____

Physician's Name (Printed/Typed) Address

_____ _____ _____

Physician's Signature (Stamp not acceptable) Date Telephone Number

****

SECTION TWO: To be completed by Parent(s)/Guardian(s)

I/We, as parent/guardian of _____, provide our express authorization and permission for _____ to self-administer _____ while in school and/or during school activities/athletics.

In accordance with Board Policy and Regulation 5330 and N.J.S.A. 18A:40-12.3, I/we have been advised, understand and acknowledge that the Board, the District and any of its employees or agents shall have no liability as a result of any injury to my child that is caused by or arises out of the self-administration of any medication.

I/We further understand and acknowledge that in accordance with N.J.S.A. 18A:40-12.3, I/we must indemnify and hold harmless the Board, the District and any of its employees or agents against any claims arising out of the self-administration.

I/We understand and acknowledge that the permission provided by this form is good for the current school year only and must be renewed for each subsequent school year.

_____	_____	_____
Signature of Parent/Guardian	Date	Emergency Telephone number

****

SECTION THREE: To be completed by school staff

After consultation with the School Nurse and School Medical Inspector, the request for self administering of medication by the student referenced above is hereby [**GRANTED/DENIED**] (select one).

_____	_____
Signature of School Principal	Date

A copy of this completed form will be provided to the School Nurse and the student's parent(s)/ guardian(s).

In accordance with Board Policy and Regulation 5330, any request that is denied may be appealed to the Superintendent or his/her designee.

******A new form must be submitted for each school year******