

Summit Public Schools

MEMO

To: Parents of Children prescribed Epinephrine for Anaphylaxis

From: Summit School Nurses

RE: Epinephrine Auto-Injector Packet

In accordance with Epinephrine administration legislation N.J.S.A. 18A: 40-12.3-12.6., protocols for the delegation of another district employee, who has volunteered and is properly trained, to administer epinephrine via a pre-filled auto injector to a pupil experiencing anaphylaxis are currently in place. The school nurse will choose and designate in consultation with the Board of Education, a delegate who will be trained to administer one dose of epinephrine via a pre-filled auto injector, in the absence of the school nurse, when the nurse is not physically present. Please keep in mind that the delegate is a volunteer, must be willing to learn the procedure, assume the responsibility and successfully complete the training, demonstrating competency.

Every effort will be made to obtain and train a delegate(s) for your child, however in the event that there is no delegate available and in the absence of the school nurse, if medication is not available or you have not replaced an expired medication, emergency management via a 911 call will be implemented.

In best meeting the health needs of your child with a life threatening allergy, there are several forms that must be completed by your child's physician in addition to the parental information, signatures and consents, all which are required. These forms include:

- **FARE. Food Allergy Anaphylaxis Emergency Care Plan. Parents must complete the reverse (pg2) and sign.**
- **Student Allergy Information Nursing Assessment** (To be completed by Parent)
- **Individualized Health Plan: Prevent Anaphylaxis** (Copy for your review as an electronic version will be created for your child)

Please make sure that you allow sufficient time for your health care provider to complete these forms. **The plan cannot take effect until all required documents are completed with ALL appropriate signatures, provider's office stamp and documents are received in the Health Office along with the prescribed pharmacy labeled medications.** Please call our office to schedule a meeting to determine how to best implement this plan. Return all forms on or before the first day of the school year, or the first day your child is returning to school after the medication has been prescribed.

Thank you for your anticipated cooperation.

Summit School Nurses

Summit Public Schools

MEMO

To: Padres de Estudiantes con receta para Epinephrine para prevenir Anaphylaxis

From: Summit School Nurses

RE: Epinephrine Auto-Injector Packet

De acuerdo a la legislación de Nueva Jersey acerca de la administración de epinephrine a los estudiantes en las escuelas, la cual incluye que otro empleado del distrito, voluntario puede ser entrenado apropiadamente para administrar la epinephrine auto-inyectable a un pupilo que experimenta anaphylaxis. La enfermera escolar escogerá el designado empleado, siguiendo las normas de la Board of Educación y este podrá administrar una dosis de epinephrine auto-inyectable en la ausencia de la enfermera, cuando la enfermera no esté presente.

Se tratará lo más posible de obtener un voluntario que se pueda entrenar y delegar. Si no hay delegado apropiado y en la ausencia de la enfermera, si no hay medicamento en la escuela, o si usted no ha traído un medicamento después que el otro expire, 911 será llamado para asistir al estudiante.

Para satisfacer de la mejor manera posible las necesidades de salud de su hijo con una alergia que pone en peligro su vida, hay varios formularios que deben ser completados por el médico de su hijo, además de la información de los padres, las firmas y los consentimientos, todos los cuales son necesarios. Estos formularios incluyen:

- **FARE. Food Allergy Anaphylaxis Emergency Care Plan (Medico) Los padres deben completar la pagina 2 (reverso) y firmar**
- **Información sobre la alergia del estudiante Evaluación de enfermería** (A completar por los padres)
- **Plan de salud individualizado: Prevenir la anafilaxia** (Copia para su revisión ya que se creará una versión electrónica para su hijo)

Por favor, asegúrese de dejar suficiente tiempo para que su proveedor de atención médica complete estos formularios. **El plan no puede entrar en vigor hasta que todos los documentos requeridos sean completados con TODAS las firmas apropiadas, el sello de la oficina del proveedor y los documentos sean recibidos en la Oficina de Salud junto con los medicamentos recetados etiquetados en la farmacia.** Por favor llame a nuestra oficina para programar una reunión para determinar la mejor manera de implementar este plan. Devuelva todos los formularios en o antes del primer día del año escolar, o el primer día en que su hijo regrese a la escuela después de que el medicamento haya sido prescrito.

Gracias por su cooperación anticipada.

Enfermeras de la Escuela Summit

SUMMIT PUBLIC SCHOOLS

Student Allergy Information Nursing Assessment (To be completed by Parent)

Student Name _____ D.O.B. _____ Teacher _____

Indicate Allergies:

_____ Insect Stings (circle): Bees Wasp Other: _____

_____ Food (circle): Peanut Tree Nuts Milk Soy Eggs Fish Shellfish

Other: _____

_____ Latex Allergy Other contact Allergy: _____

_____ Drug/Medication Allergy (List): _____

List symptoms when reaction occurred:

_____ Breathing difficulty _____ Coughing _____ Wheezing

_____ Swallowing difficulty _____ Vomiting _____ Loss of Consciousness

_____ Swelling: Describe Location & Severity _____

_____ Hives location: _____ Other: _____

Most recent reaction date: _____ Epinephrine needed? Yes / No

Has Epinephrine ever been administered? Yes / No Date administered: _____

Hospitalization or emergency room care needed in the past year for allergies? Yes / No

Does your child know how to self-administer Epinephrine Auto-injector? Yes / No

Has your child's physician instructed your child on its use? Yes / No

Indicate medication use (required) and any additional details:

Are there any other changes in your child's health since last September? _____

Are you available to go on class trips? Yes / No

_____ I will provide my child with his/her own snack for the classroom

I have read and reviewed the Medication Administration for the Nurse and Delegate order Allergy Action Plan and IHP (reverse side) and understand the content of each form. I will provide the School Nurse with information related to changes in my child's condition, treatment or medication, occurring during the school year. I will contact the School Nurse informing of any school sponsored extracurricular activities my child will participate during the school year. I will also contact the Coach, Classroom Teacher and/or Staff in Charge of any such extracurricular activity and will inform them of my child's allergy. Permission is granted for Nurse to share information regarding my child's life threatening allergy with teaching staff. Information regarding my child's life threatening allergy **may also** be shared with the following (**Parent MUST initial for approval**):

_____ Classmates _____ Families of classmates

_____ My child's name may be included when notifying as approved

Parent/Guardian Signature: _____

Date: _____

ESCUELAS PÚBLICAS DE SUMMIT

Información sobre Alergias del estudiante, Evaluación de Enfermería (Para ser completado por los padres)

Nombre del Estudiante _____ Fecha de Nacimiento _____ Profesor _____

Indique Alergias:

_____ Picaduras de insectos (círcule) : Abejas o Avispas Otros : _____

_____ Comida (Haga un círculo) : Cacahuete Nueces de Árbol Leche Soja Huevos
Pescado/Marisco Otro: _____

_____ Latex Alergia Alergia a otro contacto : _____

_____ Alergia a Medicamentos (Lista) : _____

Lista de los síntomas cuando se produjo la reacción :

_____ Dificultad respirando _____ Tos _____ Silbido al respirar

_____ Dificultad al tragar _____ Vómitos _____ Pérdida del conocimiento

_____ Hinchazon/ Edema : Describir donde y severidad _____

_____ Urticaria donde : _____ Otra reaccion: _____

La reacción más reciente : _____ Necesito Epinefrina Sí /No_

Alguna vez se le ha administrado epinefrina Sí / No Fecha administrada : _____

Hospitalización o emergencia necesario en el pasado año para las alergias Sí / No

¿Sabe su hijo cómo autoadministrarse la epinefrina auto - inyector ? Sí / No

¿Ha dado instrucciones su médico a su hijo en el uso de epinefrina? Sí / No

Indique el uso de medicamentos necesarios y detalles adicionales:

_____ ¿Hay otros cambios en la salud de su hijo desde el pasado año en Septiembre ?

_____ ¿Está usted disponible para ir de viajes de la clase ? Sí / No

_____ Yo le mando a mi hijo(a) su propia merienda para el aula

He leído y revisado la Administración de Medicamentos para la Enfermera y el Plan de acción del Delegado y Plan de Salud (reverso) y comprendo el contenido de cada formulario. Le dejare saber a la enfermera de la escuela información relacionada con cambios en la condición, el tratamiento o la medicación de mi hijo, que ocurran durante el año escolar. Me pondré en contacto con la enfermera de la escuela informando de todas las actividades extracurriculares patrocinadas por la escuela en la cual mi hijo participará durante el año escolar. También me pondré en contacto con el entrenador, los maestros y el personal a cargo de cualquier actividad extracurricular y les informaré de la alergia de mi hijo. Se concede permiso para que la enfermera de información sobre la alergia que puede causar peligro de vida a mi hijo, con el personal de enseñanza. La información sobre la alergia de peligro de vida de mi hijo también puede ser compartida con los siguientes **(padres deben poner sus iniciales)** :

_____ Compañeros de clase _____ Las familias de los compañeros de clase

_____ El nombre de mi niño puede ser incluido para notificar segun aprobado

Padre / Tutor Firma: _____ Fecha: _____

Name: _____ D.O.B.: _____

Allergic to: _____

 Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

**PLACE
PICTURE
HERE**

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

Extremely reactive to the following allergens: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

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. **ADMINISTER 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
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, 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 (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

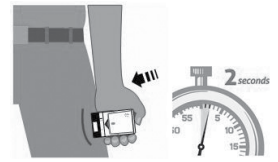
Antihistamine Dose: _____

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

☐ Patient may self-carry ☐ Patient may self-administer

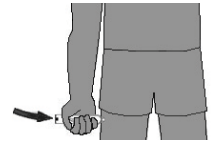
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



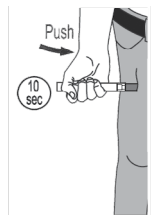
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. 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.
3. 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).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



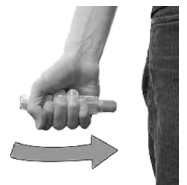
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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.



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.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Food/Contact Allergy - Copy

Assessment Data

Life Threatening Allergy that can result in Anaphylaxis

Nursing Diagnosis

Potential for alteration in breathing patterns/gas exchange related to bronchospasm and inflammation of the airway if exposure to allergen.

Potential for Knowledge deficit about anaphylaxis and/or allergen.

Potential for noncompliance with prescribed medication(s) related to knowledge deficit regarding need for emergency medication administration.

Student Goals

Student will be able to state food allergen.

Student will have knowledge to avoid contact or ingestion of food allergen.

Student will be able to participate in school activities and trips with modifications as needed.

Student will not experience Anaphylaxis.

Interventions

Nurse will educate Staff/Student re: Allergen signs/symptoms of allergic reaction.

Development of Emergency Plan including accommodations needed for Class Trips & school sponsored Extracurricular activities.
Parent available for trip Yes / No

Notification of Food Services, Cafeteria Personnel, PTO/Class parents of need for allergen free food and/or supplies for classroom as necessary.

Parent will supply prescribed medication & orders (according to SBOE policy) and will inform Nurse of any school sponsored extracurricular activity involvement and contact such said Coach/Teacher/Staff.

Student will be provided with alternate meals or snacks when needed.

Informational material distributed to school Staff in September re: Anaphylaxis Management

Informational material sent home to parents regarding food allergies and classroom awareness.

Nurse or Trained Designee will administer medication as per order (SBOE anaphylaxis Protocol

Outcomes

Student will be able to participate in classroom/school activities with modifications PRN.

Staff (teachers, assistants, and cafeteria personnel) will have knowledge of student's allergen.

Student will be able to recognize signs & symptoms (i.e. shortness of breath, itchy, hives) and advise teacher/adult in charge/nurse if experiencing symptoms.

Student will immediately inform teacher/adult in charge/nurse if suspected ingestion or contact to allergen has occurred.

Student will be aware of allergen and avoid contact or ingestion.

Developed by Summit School Nurses