The Somerset Hills School District

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Student Name: _____
Date of Birth: _____ School Year: _____
Allergic To: _____

Signs of Allergic Reaction: Circle all that apply

Systems:	**Symptoms:**
Mouth	Itching and swelling of the lips, tongue or mouth
Skin	Hives, itchy rash, and/or swelling about face or extremities
Throat	Itching and/or tightness in the throat, hoarseness and cough
Abdomen	Nausea, abdominal cramps, vomiting and/or diarrhea
Lungs	Shortness of breath, repetitive cough, wheezing or chest tightness
Heart	Thready pulse, fainting

All above symptoms can potentially progress to a life-threatening situation.

I hereby certify that the student listed above has been instructed in and is fully capable of the self-administration of the EpiPen. This student may carry his or her EpiPen. **Yes** _____ **No** _____

Action Plan for an Allergic Reaction:

Choose from the following options:

1. **Benadryl**
   NO _____
   YES _____ **Benadryl** _____ **mg. p.o.**
   Notify parent. Students with allergic reaction will be sent home.

In the absence of the school nurse, the order for Benadryl should be disregarded and epinephrine is to be immediately administered by the designated delegate.

2. **Epinephrine auto-injector 0.15mg** ___
   Epinephrine auto-injector 0.3mg ___

If symptoms of anaphylaxis persist repeat EpiPen administration in 5-15 minutes.

YES _____ **NO**_____

Call the Rescue Squad or 911 and ask for advanced life support. Notify parent/guardian. Transport to the nearest Emergency Room. Student must have access to epinephrine for school related activity and/or field trip.

Physician Signature: _____ **Date:** _____
Physician Stamp:

Parent Signature: _____ **Date:** _____