

Bedminster Township School

AUTHORIZATION FOR ADMINISTRATION OF SINGLE UNIT DOSE EPINEPHRINE AT SCHOOL

(Please complete both sides.)

This form must be completed by a PHYSICIAN/APN/PA and PARENT **ANNUALLY** for any student requiring epinephrine while in school or at a school-sponsored event.

Section I: To be completed by the Physician/APN/PA:

STUDENT NAME: _____ DOB: _____ GRADE: _____

ALLERGY TO: _____

Asthmatic Yes* () No () *Higher risk for severe reaction

The student's possible symptoms of Anaphylaxis are: _____
or _____ Unknown at this time but the student is at risk for future anaphylaxis.

Location of epinephrine (check all that apply): _____ with student _____ with nurse _____ other _____

Single Unit Epinephrine Product Choice and Dosage:

Epinephrine: via IM Injection (select one): _____ Epinephrine auto-injector 0.3mg up to 2 doses PRN

_____ Epinephrine auto-injector 0.15mg up to 2 doses PRN

OR

Epinephrine: Via Nasal Route* (select one): _____ Neffy 2mg nasal spray up to 2 doses PRN

*May not be delegated _____ Neffy 1mg nasal spray up to 2 doses PRN

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Consider for Grade 8 students attending Bedminster School Trips)

Please check all that apply:

P.L. 2007, c 57 directs that a student may be permitted to self-administer medications for potentially life-threatening illnesses provided proper procedures are followed:

_____ This student has a potentially life-threatening allergy and will carry epinephrine at all times in school or when attending a school sponsored event

_____ This student understands, has been instructed, and is capable of the proper technique of self-administration of the prescribed medication(s)

_____ This student is aware that he/she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to an adult immediately

_____ The student requires sitting at an allergy friendly cafeteria table

_____ The student does not need to sit at an allergy friendly cafeteria table.

_____ Parent/Guardian may choose cafeteria seating (allergy friendly table or not)

Physician Signature: _____ Date: _____ Physician's

Stamp:

SECTION II- To be completed by parent/guardian:

Student _____ Grade _____

My child requires emergency administration of a Single Unit Dose Epinephrine product in the event of anaphylaxis.

I consent to the following for the 20 ____ - 20 ____ school year:

- I will assure that the medication is in its original prescription container.
- I understand that it is my responsibility to ensure that the student has the medication available at school at all times.
- I will be responsible for noting the expiration date and replacing expired medication.
- For students allowed to carry and self-administer: Extra medication will be sent to school to be kept in the Health Office in case my child forgets to bring the prescribed medication to school.
- I give permission for my child to receive medication at school as prescribed by my child's physician.
- I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.
- I give permission for the school nurse to share this medical information with members of the district staff who have direct responsibility for my child in school or at a school sponsored event.
- I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration of medication by the pupil and/or staff, and we, the parents or guardians, indemnify and hold harmless the school district and its employees or agents against any claims arising out of the administration or self-administration of medication by the pupil and/or staff. Any person who acts in good faith in accordance with the requirement of P.L. 2007, c 57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that section.
- I will contact the school nurse with any questions or changes in my child's health condition

Parent/Guardian Signature: _____ Date: _____

Emergency contacts – Name/Relationship (List parent/guardians first) – Telephone numbers

1. _____ Home _____ Cell _____ Work _____

2. _____ Home _____ Cell _____ Work _____

Designation of Administration of Epinephrine

The certified school nurse may designate, in consultation with the Building Administrator, another employee of the district to administer a pre-filled single dose auto-injector mechanism containing epinephrine when the school nurse is not physically present at the scene. The employee(s) will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education. Delegates are assigned according to activity-sports, clubs & trips

PLEASE CHECK ONE ANSWER:

_____ I give consent for a trained employee(s) of the district to administer epinephrine in the event the school nurse is not present at the scene. I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from administration of a single dose of epinephrine product, and that I indemnify and hold harmless the district and its employees or agents against any claims arising from the administration of a pre-filled single dose of epinephrine.

_____ I do not consent for an employee to be designated as an epinephrine delegate for my child.

Student Self Administration*

_____ I allow my child to carry and self-administer epinephrine

** suggested for students in Grade 8*

_____ I do not allow my child to carry and self-administer epinephrine

who attend school trips, if appropriate

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____