

**PATERSON PUBLIC SCHOOLS**

SCHOOL # \_\_\_\_\_

**PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT (20\_\_-20\_\_)**

Date Given to Parent / Guardian \_\_\_\_\_ Date returned \_\_\_\_\_

Student's name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

The above student is allergic to: \_\_\_\_\_

Previous episode of anaphylaxis  Yes  No

Asthmatic  Yes  No

**MEDICATIONS**

**ANTIHISTAMINE:** \_\_\_\_\_

MEDICATION / DOSE / ROUTE

MEDICATION / DOSE / ROUTE

**EPINEPHRINE:**

EpiPen (0.3mg)     EpiPen Jr. (0.15 mg)     Other \_\_\_\_\_  
 Twinject (0.3mg)     Twinject (0.15mg)  
 Repeat dose in \_\_\_\_\_ Minutes

		<u>Give Checked Medication</u>	
<b>CONTACT</b>	Contact only with allergen(s), _____ but with no symptoms	( ) Epinephrine	( ) Antihistamine
<b>SKIN</b>	Hives, itchy rash, swelling of face or extremities	( ) Epinephrine	( ) Antihistamine
<b>MOUTH</b>	Itching, tingling, burning, or swelling of lips tongue and mouth.	( ) Epinephrine	( ) Antihistamine
<b>THROAT</b>	Tightening of throat, hoarseness, hacking cough	( ) Epinephrine	( ) Antihistamine
<b>GUT</b>	Abdominal cramps, nausea, vomiting, diarrhea	( ) Epinephrine	( ) Antihistamine
<b>LUNGS</b>	Repetitive cough, wheezing, shortness of breath	( ) Epinephrine	( ) Antihistamine
<b>HEART</b>	Thready pulse, low blood pressure, fainting, pale or bluish skin	( ) Epinephrine	( ) Antihistamine
<b>GENERAL</b>	Panic, sudden fatigue, chills, fear of impending doom	( ) Epinephrine	( ) Antihistamine
<b>OTHER</b>		( ) Epinephrine	( ) Antihistamine

**MEDICATION ADMINISTRATION ORDER:**

**CHOOSE ONE**

- Give Epinephrine only \*(Delegate will be assigned)
- Give Antihistamine & Epinephrine at same time \*(Delegate will be assigned)
- Give Antihistamine first, observe for further symptoms and give Epinephrine PRN

**\*Please note - In the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

- This student has been trained and is capable of self-administration of the following medication(s) named above:
  - Epinephrine - single dose auto-injector
  - Epinephrine & Antihistamine - single dose auto injector & premeasured dose of antihistamine
  - This student is not capable of self-administration of the medications named above.
- \* Under NJ State Law, orders for antihistamine alone cannot be self administered.

Physician's signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Physician's Stamp:

School Doctor's signature \_\_\_\_\_

Date \_\_\_\_\_

# Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:60-12.8) (Physician's Orders)



Parents/Guardian Use Only

The prescribed antihistamines and Epinephrine auto-injector(s) must be provided to the school nurse by the parent/guardian, and all medications must be provided in the original pharmacy container. Permission for the self-administration of prescribed medication is effective for the school year for which it is granted and must be renewed for each subsequent school year.

Select one to sign and date:

1. I verify that my child \_\_\_\_\_ has a potentially life threatening illness and has been instructed in self-administration of the prescribed medication in a life threatening situation. I hereby give permission for my child to self-administer prescribed medication. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of self administration of medication by my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

2. I verify that my child \_\_\_\_\_ has a potentially life threatening illness and is unable to self-administer the prescribed medication in a life threatening situation. I hereby request the school nurse to delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from administration of the medication to my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of administration of medication to my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Please sign:

I understand that under NJ State law, a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

**SCHOOL USE ONLY**

\_\_\_\_\_  
Signature of School Nurse

\_\_\_\_\_  
Date

PATERSON PUBLIC SCHOOLS DISTRICT  
90 DELAWARE AVENUE  
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Date \_\_\_\_\_

Name and Address of Hospital or Health Care Provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To Whom It May Concern:

This is to certify that I, \_\_\_\_\_, the  
(Parent/Guardian Name)  
parent / legal guardian of \_\_\_\_\_ Grade \_\_\_\_\_, do  
(Student Name)  
hereby give my written consent for you to share information and/or release any medical records  
that you might have in your possession concerning \_\_\_\_\_ DOB \_\_\_\_\_.  
(Student Name)

Please send records to the attention of the School Nurse at:

School Nurse's Name \_\_\_\_\_

School Name and Address → \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of  
Parent or Guardian: \_\_\_\_\_

Signature of  
School Nurse: \_\_\_\_\_ Telephone # 973-321-\_\_\_\_\_



Charles J. Riley School 9 Health Office  
6 Timothy Street  
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abermudez@paterson.k12.nj.us  
Elenh Andreanidis, Vice-Principal  
eandreas@paterson.k12.nj.us

**Parent/ Guardian Permission to Release and Exchange  
Confidential Health Information**

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_  
Hereby authorize the exchange of any information regarding my child to occur between  
the school nurse and staff members who participate in my child's care while they are in  
school.

This information may also be shared with the intervention and Referral Service Team,  
the Child Study Team and/or the 504/ Guidance Team if needed.

This authorization is in effect for School Year \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

School Nurse (Printed) \_\_\_\_\_

School Nurse Signature \_\_\_\_\_