



Manville School District

Dr. James V. McLaughlin • Special Services Department • 908.231.8500 x8536
1100 Brooks Blvd., Manville, NJ 08835 • www.manvilleschools.org

Allergy and Anaphylaxis Medication Orders and Emergency Care Plan (Valid for Current School Year Only)

Name of student: _____ DOB: _____

This student has a documented life threatening allergy to the following (indicate):

If there is reasonable suspicion that this child has been stung, has ingested the above named allergen, or if signs of anaphylaxis develop, I give permission for the nurse or trained delegate to follow the protocol described below.

Healthcare Provider Check One:

- I certify the student has been trained and is capable of self-administering epinephrine via a pre-filled auto-injector.
- I certify the student is not capable of self-administration and requires the school nurse or trained delegate to administer epinephrine via a pre-filled auto-injector.

Epinephrine Auto-injector (Specify brand, dose, route): _____

- Administer Immediately
- Administer only if signs of anaphylaxis develop

Prescriber may indicate specific signs: _____

If an antihistamine is ordered to be given in addition to the epinephrine, indicate medication, dose, route:

Call 911 and parent immediately.



Signature of Healthcare Provider Date Office Telephone

Parent/Guardian Permission for Administration of Epinephrine via Delegate

I understand that if my child is unable to self-administer epinephrine via a pre-filled auto-injector, a delegate selected and trained by the school nurse may administer epinephrine via a pre-filled auto-injector if the school nurse is not available. I acknowledge that if the requirements of N.J.S.A. 18A:40-12.5 and 12.6 P.L. 1997, c.368 are followed; including that the delegate may or may not be certified to perform cardiopulmonary resuscitation; the Board, its employees, and agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I will indemnify and hold harmless the Board, its employees, and agents against any claim arising out of the administration of the epinephrine to my child. I understand that this permission is effective for the **current** school year only and must be renewed for each subsequent school year. It is my responsibility to provide the school nurse with written orders from a physician for the administration of epinephrine and to provide the medication and/or replacement as necessary.

Parent/Guardian Signature: _____ Date: _____



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Anaphylaxis Emergency Plan of Care and Contact Form

Student: _____ D.O.B.: ___/___/_____ Grade: _____

Allergy: _____

Does the student have medical documentation of Asthma? Y N

Signs of Anaphylaxis can include the following:

- Lung (Respiratory): Shortness of breath, wheezing, repetitive cough
- Heart: Pale or bluish color, faint, weak pulse, dizziness
- Throat: Tightness, hoarse, difficulty breathing or swallowing
- Mouth: Swelling of lips/tongue, numbness, itchiness
- Skin: Hives, widespread redness
- Abdomen/Stomach: Vomiting, diarrhea, nausea
- Other: may feel anxious, feeling of something bad happening



Student Picture

INJECT EPINEPHRINE IMMEDIATELY. DO NOT HESITATE TO ADMINISTER.

- Initiate 9-1-1 or 911 must be called if epinephrine is given.
- State that an anaphylactic reaction has been treated and emergency medical services are required.
- Monitor the student's position to comfort.
- Consider lying on back with legs elevated, lying on side if nausea/vomiting, or sitting more upright if difficulty breathing.
- Contact the parent/guardian.
- Contact the building administrator/designee.

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

I approve this allergy/anaphylaxis care plan for my child and give permission for this plan to be followed by school personnel. I give consent for the sharing of information as needed. I assume full responsibility for providing the school with the prescribed medication(s).

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse: _____ Date: _____