PHOTO

AUTHORIZATION OF EMERGENCY TREATMENT

Palisades Park School District

ECC 201-947-2761 / Lindbergh Elementary 201-947-3337 / Jr-Sr High 201-941-1103

Name: _____ DOB: _____ Grade: _____

Allergic to: _____

1. If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows:

Symptoms:		Give Medication checked "X"*		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine	☐ EpiPen	
Skin	Hives, swelling on face or extremities, itchy rash	☐ Antihistamine	☐ EpiPen	
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine	☐ EpiPen	
Throat	Tightening of throat, hoarseness, hacking cough	☐ Antihistamine	☐ EpiPen	
Lung	Shortness of breath, repetitive coughing, wheezing,	☐ Antihistamine	☐ EpiPen	
Heart	Thready pulse, passing out, fainting, pale, blueness	☐ Antihistamine	☐ EpiPen	
General:	Panic, sudden fatigue, chills, fear of impending doom	☐ Antihistamine	☐ EpiPen	
If a food allergen has been ingested, but *no symptoms*:		☒ Antihistamine	☐ EpiPen	☐ Other
If a reaction is progressing (several of the above areas affected):		☒ **Antihistamine**	☒ **EpiPen**	

Medication Doses:

Antihistamine (liquid diphenhydramine, Benadryl™) or Cetirizine, Zyrtec™ :

Give _____ Teaspoon(s), _____cc (_____mg) by mouth.

Epinephrine:

EpiPen™ [Epi-Pen_____ (_____mg)] injected once into upper outer thigh

Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

Call 911 (or Ambulance service and phone number:_____)

State that the child had a severe allergic reaction, and additional epinephrine doses may be needed

Additional contact information:

Nearest Hospital _____ Phone _____ Address

Allergist Name _____ Phone _____

Pediatrician Name _____ Phone _____

Parent's Name (other contacts) and Contact Numbers

Name _____

Phone (1) _____ Phone (2) _____

Name _____

Phone (1) _____ Phone (2) _____

Other allergies, medication allergies, medical conditions:_____ Approximate Weight:_____ lbs

DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!

*Additional boxes may be checked depending upon specific patient history

_____ _____

Physician's Signature Date Parent's Signature Date

Parent/Guardian: By signing this acknowledgement, I understand that the Palisades Park Board of Education, it's employees or agents shall incur no liability as a result of any injury arising from the administration of medication, and that I hereby indemnify and hold harmless the Palisades Park Board of Education, it's employees, or agents against any claims arising out of the administration of this medication.