

PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____
Allergy to: _____ School Year: _____ Effective Date: _____
Weight: _____ lbs. Asthma: [] Yes (higher risk for a severe reaction) [] No
NOTE: Epinephrine Location: _____ Nurses Signature: _____

Extremely reactive to the following allergens: _____
THEREFORE:
[] If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.
[] If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS

LUNG Short of breath, wheezing, repetitive cough	HEART Pale, blue, faint, weak pulse, dizzy	THROAT Tight, hoarse, trouble breathing/ swallowing	MOUTH Significant swelling of the tongue and/or lips

			OR A COMBINATION of symptoms from different body areas.
SKIN Many hives over body, widespread redness	GUT Repetitive vomiting, severe diarrhea	OTHER Feeling something bad is about to happen, anxiety, confusion	

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- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS

NOSE Itchy/runny nose, sneezing	MOUTH Itchy mouth	SKIN A few hives, mild itch	GUT Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: [] 0.15 mg IM [] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

This student is not capable of self-administration of the medications named above.

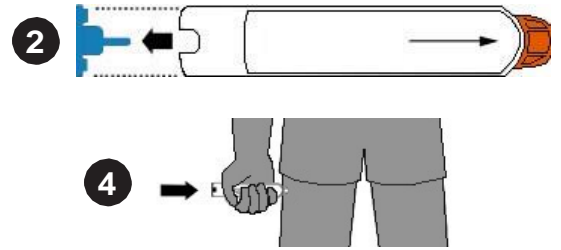
This student is capable of self-administration of the medications named above.

Physician Name (Print)

PARENT/GUARDIAN SIGNATURE DATE PHYSICIAN SIGNATURE DATE PHYSICIAN STAMP

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Please sign

I give my consent that, a trained delegate may administer epinephrine via a prefilled auto injector 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. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the North Brunswick Township School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and North Brunswick School District Policy are followed, I shall indemnify and hold harmless the North Brunswick School District and its employees or agents against any claims arising out of administration of medication to my child.

_____ Parent Signature

_____ Date

I understand it is my responsibility to notify the School Nurse if my child is attending any school sponsored activities outside of the school day. _____ Parent Signature _____ Date

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____