WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

P.O. Box 428, School Street
Woodbridge, New Jersey 07095

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HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Authorizations are effective for one school year only and must be renewed annually.

Student's name:_____ Birth date:_____ Grade/Teacher _____

The above student is allergic to: _____

Previous episode of anaphylaxis: Yes No Potential for life threatening allergic reaction: Yes No

Asthmatic: Yes* No *Higher risk for severe reaction

STEP 1 A: TREATMENT WHEN SCHOOL NURSE PRESENT

Symptoms	Give Checked Medication
If there is reasonable suspicion that the student has been stung or ingested the allergen, but NO symptoms	Epinephrine Antihistamine
Mouth - Itching, tingling	Epinephrine Antihistamine
Swelling of the lips, tongue, mouth	Epinephrine Antihistamine
Skin - Hives, itchy rash	Epinephrine Antihistamine
Swelling of the face or extremities	Epinephrine Antihistamine
Gut - Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine Antihistamine
Throat - Tightening of throat, hoarseness, hacking cough	Epinephrine Antihistamine
Lung - Shortness of breath, repetitive coughing, wheezing	Epinephrine Antihistamine
Heart - Thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine Antihistamine
Other	Epinephrine Antihistamine
If reaction is progressing (several of the above areas affected) give	Epinephrine Antihistamine

Dosage

Epinephrine: inject intramuscularly: EpiPen EpiPen, Jr. Other:_____

May repeat Epinephrine _____ minutes after 1st dose or as needed if symptoms continue to progress.

Antihistamine: give (medication, dose, route) _____

STEP 1B: TREATMENT BY DELEGATE WHEN NURSE NOT PRESENT

Yes No Epinephrine may be delegated to a trained volunteer.

***Please note- in the absence of a school nurse, a trained delegate will give epinephrine immediately for any symptoms and any antihistamine order will be disregarded**

STEP 1C: TREATMENT BY STUDENT (SELF-ADMINISTRATION)

This student has been trained and is capable of self-administration of the following medication(s) named above:

Epinephrine – single dose unit Epinephrine & Antihistamine – single dose units

***Under NJ state law, orders for antihistamine alone can not be self-administered**

This student may **NOT** self-administer the above medication(s).

STEP 2

1. Call 911 immediately and state that student is having an anaphylactic reaction, then contact parent.
2. Begin CPR if pulse and breath are absent.
3. Make child as comfortable as possible until ambulance arrives.
4. **Child must be transported to emergency room by EMS, even if symptoms have resolved.**

_____ _____ _____

Healthcare Provider's Signature Date Healthcare Provider's Stamp

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PARENT PERMISSION AND RELEASE FORM FOR EMERGENCY ADMINISTRATION OF MEDICATION
Authorizations are effective for one school year only and must be renewed annually.

Student's name:_____ Birth date:_____ Grade___

STUDENTS THAT MAY NOT SELF-ADMINISTER MEDICATION

1. 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 or delegate, if the school nurse is not present, to administer the prescribed medication to my child. I further acknowledge that the Woodbridge 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 Woodbridge Township School District Policy are followed, I shall indemnify and hold harmless the Woodbridge Township School District and it's employees or agents against any claims arising out of administration of medication to my child.

The following employees are trained designees:

_____

_____

_____
Parent/Guardian Signature Date

STUDENTS THAT MAY SELF- ADMINISTER MEDICATION

2. I verify that my child _____ has a potentially life threatening illness and **has been instructed in the 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 Woodbridge Township School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by NJ law and Woodbridge Township School District policy are followed, I shall indemnify and hold harmless the Woodbridge Township School District and it's employees or agents against any claims arising out of self administration of medication by my child.

_____ _____
Parent/Guardian Signature Date

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