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WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

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

Student name _____ D.O.B. _____ Gr./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 IS 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 the 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 1-B: TREATMENT BY DELEGATE WHEN SCHOOL 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 1-C: 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 cannot be self-administered

OR

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

STEP 2:

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

_____ Healthcare Provider's Signature

_____ Date

_____ Healthcare Provider's Stamp

Revised 2016
Regulation #5141.21

WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

P.O. Box 428, School Street
Woodbridge, NJ 07095

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Parent Permission and Release Form for Emergency Administration of Medication

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

Student's Name: _____ D.O.B. _____ 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 designee, 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 N.J. law and Woodbridge Township School District Policy are followed, I shall indemnify and hold harmless the Woodbridge Township School District and its 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 N.J. law and Woodbridge Township School District policy are followed, I shall indemnify and hold harmless the Woodbridge Township School District and its employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____
Parent/Guardian Signature Date

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