**For Severe Allergies (requiring Epi-pen auto injector +/or Benadryl),** the following **is required every school year on the first day of school**:
(Number of pages including this cover sheet is 5 )

1. Emergency Health Care Plan (Epi 3)- **(Parent and physician signature required)**
2. Permission for delegating epi-pen administration (epi-1) – **(Physician completes and signs)**
3. Permission for delegating epi-pen administration (epi-2)- **(Parent completes and signs)**
4. Send in Epi-pen auto injector **in current pharmacy box with label**
5. **If Benadryl ordered must be ordered by a physician and signed by parent** ( must be filled in on Epi 3 Form)
6. You must also **send in** the Benadryl in its original container. **Please note that Benadryl may not be given by a delegate. The delegate is only trained for the epi-pen.**
7. Self medication form if applicable **(parent and physician complete)**

# EMERGENCY HEALTH CARE PLAN - EPI 3

Student's Name_____ DOB _____ Teacher_____

Allergy to _____

Trained Delegate_____

School Nurse_____

## SIGNS OF ALLERGIC REACTION INCLUDE:

| Systems | Symptoms |
|---|---|
| Mouth | itching and swelling of the lips, tongue or mouth |
| Throat* | itching and /or a sense of tightness in the throat, hoarseness, and hacking cough |
| Skin | hives, itchy rash, and/or swelling about the face or extremities |
| Gastrointestinal | nausea, abdominal cramps, vomiting, diarrhea |
| Respiratory* | shortness of breath, repetitive coughing, and/or wheezing |
| Cardiovascular* | 'thready' pulse, passing out |

Specific symptoms for this student may include: _____

_____

***All above symptoms can potentially progress to a life-threatening situation.*** The severity of symptoms can quickly change.

## ACTION:

- ☐ If ingestion is suspected
- ☐ If stung by bee
- ☐ Experienced other life threatening allergy
  - Benadryl _____mg _____ (administered *by **nurse*** only)
  - Inject: ___ Epi Pen ___ Epi-Pen Jr. **
  - Call 911
  - Call: ___ Mother(_____) Father(_____) or ___ emergency contact
  - Call: Dr._____ at _____
  - Continue to monitor student for absent breathing/pulse until EMT arrives.
  - Initiate CPR if pulse and/or breathing absent
  - Offer reassurance to student, as appropriate

***** *Give used epi-pen to EMT***

_____ _____

Parent Signature Date

_____ _____

Doctor's Signature Date

## SCHOOL HEALTH SERVICES

## PHYSICIANS PERMISSION FOR DELEGATING THE ADMINISTRATION OF AN EPI-PEN WHEN THE SCHOOL NURSE IS NOT PRESENT

**Student's Name:**_____**D.O.B.**_____

**Anaphylactic Allergy to:**

- ☐ **Insect stings such as bees or wasps** _____
- ☐ **Exposure to the following allergen**_____
- ☐ **Food Allergy to**_____

This student may experience a life threatening reaction to the allergens listed above, and does not have the ability to self-administer an injection of epinephrine.
I understand that when the school nurse is not available, a trained delegate will administer the Epi-pen or Epi-pen Jr. I also understand that if the school nurse or the trained delegate is not available,
911 will be called.

If there is reasonable suspicion that the above named child has been stung or has ingested the above named allergen, or if any of the following signs of anaphylaxis develop,
I give my permission for the trained delegate to follow this protocol. Signs of an anaphylactic reaction include: itching or swelling of the lips, tongue, or mouth; itching or tightness in the throat,
hoarseness; hives, itchy rash, and swelling of the face or extremities; nausea, abdominal cramps, vomiting, diarrhea; shortness of breath, wheezing or hacking cough; thready pulse or passing out.

1. Administer immediately: _____Epi-pen (.3mg)
   ____ Epi-pen Jr. (.15mg)
2. Call 911 and parent immediately
3. Begin CPR if pulse or breathing is absent.
4. Make child as comfortable as possible until the ambulance arrives.

**Physician's Signature**_____**Office stamp:**

**Epi-1**

*Please note that the NJ. State Law PL 1997, C.368 allows the delegate to administer no medications except the Epi-pen or Epi-pen Jr.

# SCHOOL NURSE PROGRAM

Camden County Non-Public Schools

## PARENT PERMISSION FORM for

## DELEGATING EPI-PEN ADMINISTRATION

Student Name _____ D.O.B._____

*I give permission for the school nurse or her trained delegate to administer an Epi-pen or an Epi-pen jr. to my child _____ , for the treatment of anaphylaxis as identified by my child's doctor. I understand that if the school nurse is not available, a trained delegate will administer the Epi-pen. I also realize that if for some reason, neither the school nurse nor the trained delegate is available, 911 will be called.*

*I acknowledge that if the established protocols are followed, the Southern New Jersey Perinatal Cooperative,, _____School and its employees shall have no liability as a result of any injury arising from the administration of the Epi-pen to my child. I indemnify and hold harmless the school and its employees or agents against any claim arising out of the administration of the Epi-pen to my child.*

*I also understand that this permission iis effective for this school year only, and must be renewed for each subsequent school year.*

Name of Delegate: _____

Parent's Signature: _____ Date: _____

*Epi-2*

# SELF-MEDICATION FORM FOR STUDENTS WITH ASTHMA OR OTHER LIFE THREATENING ILLNESSES

Student's Name_____ Age_____ Grade_____

School _____

Name of Medication_____

Dosage_____ Frequency_____ Route of Administration _____

Possible Side Effects_____

Specific Nature of Student's Illness/Condition_____

Effective Dates of Medication: From_____ To _____

*It is my understanding that the school nurse in _____School charged with the administration of medication may rely upon my directions as contained in this document. Students with asthma or other potentially life-threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and/or prevention of life-threatening illnesses or conditions during school hours, athletic events and practices, and field trips.*

*I hereby deem the above-named student to be sufficiently capable, having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his/her prescribed medication on his/her person and give authorization for self-medication of the medication listed above. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from attending physician.*

Physician's Name (print)_____

Physician's Signature_____ Date _____

Physician's Address_____ Telephone_____

**********

*As parent/guardian of the above-named child, I hereby request permission for my child to self-administer and have possession of his/her medication as described above and release_____School and its employees and its agents from liability for damages my child may suffer as a result of this request.*

*I realize self-management privileges are lost if he/she does not use medication properly. Students deemed responsible may carry their prescribed medication on their person, but must report to the school nurse with the above-mentioned medication before this policy can be instituted.*

*I also realize permission is effective for this school year and must be renewed yearly.*

*I agree that I shall indemnify and hold harmless_____School and its employees or agents against any claims arising out of the self–administration of medication by the pupil.*

Parent Signature_____ Date _____

Home Telephone_____ Work Telephone_____

***NOTE:*** 1. A separate dose of medication must be kept in the nurse's office.
2. Medication brought to school must be prescription labeled.

# MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

**Parent/Guardian Signature** Date

**********

## TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone _____

Name of Medication _____

Name of Physician _____ Phone _____

# Of Tablets Received _____

**********

## PHYSICIAN'S ORDERS

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

**Doctor's Name (please print)** **Doctor's Signature** **Date**