

Warren Township Schools / Anaphylaxis Treatment Plan

Form A

Student: _____ DOB: _____ is allergic to _____

Please provide your signature on ONE of the options below, sign and date the bottom with your physician

1. I authorize my child to self-administer epinephrine.

1. _____

YES (PARENT SIGNATURE)

- ❖ I will provide my child and the school with **TWO auto-injector epinephrine units** and/or oral meds and all forms.
- ❖ My child will **“Self Carry”** the epinephrine & 1 dose of oral medication on their person at all times.
- ❖ My child will have a trained Adult Delegate who can administer only the Autoinjector Epinephrine during school sponsored events when the school nurse is not present.
- ❖ This student is **capable** and has been instructed **by their physician** in the proper method of **self-administering** the epinephrine and/or antihistamines named above in accordance with NJ Law (N.J.S.A. 18A:40-12.3).

2. I do NOT authorize my child to self-administer Epinephrine.

2. _____

YES (PARENT SIGNATURE)

- ❖ My child will **NOT self carry** Auto-injector epinephrine or other medications.
- ❖ I will provide the Nurse with at least **TWO Auto-injector Epinephrine** and /or oral medications and physician orders.
- ❖ My child will have a trained Adult Delegate who can administer **only** the Autoinjector Epinephrine during school sponsored events when the school nurse is not present

3. My child has allergies, but is NOT anaphylactic.

3. _____

YES (PARENT SIGNATURE)

- ❖ Only Antihistamines and or Steroids will be provided with Physicians orders.
- ❖ Nurse Administration ONLY

4. My child does NOT require medical treatment for allergies.

4. _____

YES (PARENT SIGNATURE)

I acknowledge that if the procedures specified in the "Training Standards for the Administration of Epinephrine via Auto-Injectors" are followed, the district shall not have any liability as a result of any injury arising from the administration of a pre-filled, auto-injector mechanism containing epinephrine to the pupil. The parents or guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of a pre-filled, auto-injector mechanism containing epinephrine to the pupil.

Signature of Parent/Guardian

Print Name of Parent/Guardian

Date

Signature of Physician

Name, Address, Telephone of Physician

Date

INDIVIDUALIZED HEALTH PLAN FOR ANAPHYLAXIS/SEVERE ALLERGIES

FORM B

Photo
OF
STUDENT

Student: _____ Date of Birth: _____ Grade: _____

Allergy to: _____

	S/S for Treatment	Medication	Medication	Side Effects
Mouth	If a food allergen has been ingested, but NO SYMPTOMS: Itching, tingling or swelling of lips, tongue or mouth.	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Abdominal	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Throat	Tightening of throat, hoarseness, hacking cough	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Lung	Shortness of breath, repetitive coughing, wheezing	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Heart	Weak or thread pulse, passing out, fainting, pale, blue	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Other		Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	

1. **Epinephrine: IM (circle one) *EpiPen 0.3mg *EpiPen Jr. 0.15mg **Twinject 0.3mg **Twinject 0.15mg**

* (Two Auto injectors must be provided, regardless of Brand/style)

** (Delegate may ONLY give auto injector portion of the Twinject)

2. **Antihistamine:** _____ Dose: _____ Frequency: _____

3. **Other:** _____ Dose: _____ Frequency: _____

Asthma: Yes _____ No _____ Rx: _____

In the absence of the school nurse the delegate can administer Epinephrine as the initial treatment for allergic symptoms; the delegate cannot administer any oral medication.

****Physician Signature:** _____ **Date:** _____

**Physician
Stamp**

****Physician Name** _____ **Telephone:** _____

Call 911 "Allergic reaction was treated with Epinephrine transport to hospital required"

Parent /Guardian: _____ Home phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Additional Contact Name: _____ Phone: _____

Additional Contact Name: _____ Phone: _____

Delegate: _____ Delegate: _____

Locations of Auto-injector Epinephrine: 1. _____ 2. Nurse's Office

School Nurse Signature: _____ Date: _____