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

NO FAXES ACCEPTED

INDIVIDUALIZED HEALTH PLAN FOR ANAPHALYXIS/SEVERE ALLERGIES

FORM B

Photo OF STUDENT

Student: ____ **Date of Birth:** ______________**Grade:**_______

Allergy to: ____

	S/S for Treatment	Medication	Medication	Side Effects
	If a food allergen has been ingested, but NO SYMPTOMS:	Epinephrine ☐	Antihistamine ☐	
Mouth	Itching, tingling or swelling of lips, tongue or mouth.	Epinephrine ☐	Antihistamine ☐	
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine ☐	Antihistamine ☐	
Abdominal	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	Weak or thread pulse, passing out, fainting, pale, blue	Epinephrine ☐	Antihistamine ☐	
Other		Epinephrine ☐	Antihistamine ☐	

1. Epinephrine: IM (circle one) *Autoinjector Epinephrine 0.3mg *Autoinjector Epinephrine 0.15mg * (Two Auto injectors must be provided, regardless of Brand/style)

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**

****Physician Name** ____ **Telephone:** ________________________ **Stamp**

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: _________________

Revised 10/10/13 DZ