WEST MILFORD TOWNSHIP PUBLIC SCHOOLS (WMTPS)

MEDICATION FORM FOR FOOD/INSECT ALLERGIC REACTION – 2 sided

This form must be completed by a PHYSICIAN/ADVANCED PRACTICE NURSE **AND** PARENT **ANNUALLY** for any student requiring Epinephrine while in school or at a school-sponsored event.

Student's Name: _____ DOB: _____ Grade: ____School Year_____
ALLERGY TO: _____Weight_____
Asthma Yes* ( ) No ( ) ***Higher risk for severe reaction***

Location of epinephrine (check all that apply): _____with student _____with nurse_____other

SECTION 1 – SYMPTOMS:

Systems:	**If food allergen has been ingested or student stung by insect (if order is for insect sting allergy) but no symptoms:**	**Give Checked Medication** ( )Epinephrine	( )Antihistamine
Mouth	Itching, tingling or swelling of lips, tongue, mouth	( )Epinephrine	( )Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	( )Epinephrine	( )Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	( )Epinephrine	( )Antihistamine
Throat †	Itching and/or 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	Feeling something bad is about to happen, anxiety, confusion	( )Epinephrine	( )Antihistamine
	If reaction is progressing (several of the above areas affected)	( )Epinephrine	( )Antihistamine

† Potentially Life Threatening **Symptoms** (The severity of symptoms can change quickly)

ACTION FOR A MINOR REACTION:

1. If only symptoms are MINOR rash or MINOR skin itching, give **diphenhydramine** _____mg liquid **OR** tablets. **(_____ tsp. @ 12.5 mg per tsp. /diphenhydramine)**
2. Then call emergency contacts on file as provided by the parents/guardians and notify physician's office.

ACTION FOR A MAJOR REACTION:

1. If symptoms progress, and/or person has cough, hoarseness of voice, tightness of throat, wheezing, and/or shortness of breath, **immediately** give: _____Epipen 0.3 mg _____Epipen Jr. 0.15 mg
   _____Auvi-Q 0.3 mg _____Auvi-Q 0.15 mg
   _____Adrenaclick 0.3mg _____Adrenaclick 0.15 mg

***** Epinephrine may be repeated in 5-7 minutes if symptoms do not improve*****

2. **Then call 911 and ask for advanced life support**. Call emergency contacts on file as provided by the parents/guardians and notify physician's office. Student must be transported to the nearest hospital.

TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT (Please check one)
____ Delegate Order- In the absence of the school nurse, the order for antihistamine should be disregarded and Epinephrine may be administered by a trained delegate.
____This student's order should not be delegated.

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Please check all that apply):
This student is both capable and responsible for self-administering this epinephrine. _____yes _____no

Physician Signature: _____ Date: _____ Physician Stamp:

ALLERGIC REACTION/MEDICATION FORM

SECTION II – To be completed by parent/guardian:

My child, _____, a student in the West Milford Township Public School System, has a potentially life-threatening allergy that could result in anaphylaxis. This student requires emergency administration of epinephrine via a pre-filled, auto-injector mechanism containing epinephrine in the event of anaphylaxis.

My child has my permission, in accordance with P.L. 2007, c 57, to carry and self administer the prescribed medication.
( ) Yes ( ) No

In order to keep my child safe at school or at a school sponsored event, I consent to the following for the **20____/20____ school year**. **Please read and check all of the following:**

- Medication(s) will be sent to school to be kept in the Health Office.
- I will assure that the medication is in its original prescription container.
- I will note the expiration date of the medication and promptly replace any expired medication.
- When applicable to MD order, I will remind my child to have the medication with them at all times. If an antihistamine is prescribed to be given along with epinephrine for anaphylaxis, a single, pre-measured dose of antihistamine (in the original, labeled container) is to be kept with the student along with the epinephrine.
- I give permission for my child to receive medication at school as prescribed by my child's physician.
- I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications in relation to this medical issue.
- I give permission for the school nurse to share this medical information with members of the WMTPS staff who have direct responsibility for my child in school or at a school sponsored event.
- I understand that the WMTPS district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration of medication by the pupil. We, the parents or guardians, indemnify and hold harmless the WMTPS district and its employees or agents against any claims arising out of the administration or self-administration of medication by the pupil. Any person who acts in good faith in accordance with the requirement of P.L. 2007, c 57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that section.
- I will contact the school nurse with any questions or changes in my child's health condition.

If Health Care Provider has given orders for a delegate:

- I give permission for any WMTPS employee or agent (who is a trained delegate pursuant to P.L. 2007, c 57) to administer epinephrine to my child in the absence of the School Nurse (school delegate list changes each year, and will be available upon request from your Certified School Nurse). This is ordered by my child's Health Care Provider on the front of this form.

_____ _____
Parent/Guardian's Name Parent/Guardian's Name

_____ _____
Parent/Guardian's Signature Parent/Guardian's Signature

_____
Date

Emergency Contacts – Name/Relationship/Phone Numbers

1._____ (H) _____ (C) _____ (W) _____

2._____ (H) _____ (C) _____ (W) _____

3._____ (H) _____ (C) _____ (W) _____