CALIFON SCHOOL
ALLERGY ACTION PLAN

SCHOOL YEAR _____

_____ _____ _____ Picture

Student's Name Date of Birth Weight

To Be Completed by Physician or Advanced Practice Nurse

ALLERGY TO: _____

Does this student have asthma?	**Yes***	**No**	***Higher risk for severe reaction**
History of anaphylaxis:	**Yes**	**No**	
Does this student carry and self-administer their Epi-pen or Auvi-Q?	**Yes**	**No**	

ACTION FOR KNOWN OR SUSPECTED INGESTION/STING

Treatment by School Nurse or Trained Delegate:

Epinephrine: inject intramuscularly (circle one) **Epi-Pen®** **Epi-Pen Jr.®** **Auvi-Q** **Auvi-Q Jr.**

Epinephrine may be repeated by the school nurse in _____minutes, if indicated

Antihistamine: give (medication, dose, route) _____

Other: give (medication, dose, route) _____

In accordance with P.L. 2007 in the absence of a school nurse, only the epinephrine will be administered by a trained delegate.

Treatment by Student (Self-Administration)

NJ State Law allows for the self-administration of medication by a student with a potentially life-threatening illness or a life threatening allergic reaction provided proper procedures are followed.

This student may self-administer the prescribed medication(s) epinephrine and antihistamine ☐ **Yes** ☐ **No**

(If yes, complete the questions below. To have permission to self-administer, all questions listed below must be checked "yes".)

I certify that this student is capable of and has been instructed in the proper administration of this necessary medication. ☐ **Yes** ☐ **No**

This student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used the above-prescribed medication(s). ☐ **Yes** ☐ **No**

Self-Administration Dosage:
Epinephrine: student should inject immediately (circle one) **Epi-Pen®** **Epi-Pen Jr.®** **Auvi-Q** **Auvi-Q Jr.**

Please note: Under NJ state law, orders for antihistamine alone cannot be self-administered

9-1-1 WILL BE ACTIVATED AND THIS STUDENT WILL BE TRANSPORTED IMMEDIATELY AFTER SUSPECTED ALLERGEN EXPOSURE TO THE HOSPITAL EMERGENCY ROOM BY AMBULANCE.

♦ **Medical Practitioner's Stamp** _____

_____ _____

♦ **Medical Practitioner's Signature (MD, DO or Advanced Practice Nurse)** **Date**

over

TO BE COMPLETED BY THE PARENT

Physician _____ **Phone #**_____

Parent/Guardian _____ **Phone #** _____ **Cell #**_____

Parent/Guardian _____ **Phone #** _____ **Cell #**_____

Emergency Contacts: (Name/Relationship)
a. _____ **Phone #**_____ **Cell #** _____

b. _____ **Phone #**_____ **Cell #** _____

My child's previous symptoms of an anaphylactic reaction include: Check all that apply

__Swelling (eyes, lips, face, tongue)
__Shortness of breath, repetitive coughing, wheezing
__Hoarseness, tightening of throat, difficulty swallowing
__Hives, itchy rash, swelling of face or extremities
__Nausea, abdominal cramps, vomiting, diarrhea
__Thready pulse, fainting, pale
__Panic, fear of impending doom
__Cold, clammy, sweaty skin
__**Unknown** (Never had a reaction)
__Others (list): _____

Date and description of last allergic reaction included: _____

_____

Parent/Guardian Authorization (to be completed for all students)

I give permission for my child to receive medication at school as prescribed above. I also 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. Information may be shared with the staff on a need-to-know basis.

_____ _____

♦ **Parent/Guardian Signature** **Date**

Parent/Guardian Authorization for the Administration of Epinephrine by a Delegate

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates trained by the certified school nurse to administer epinephrine in the event the school nurse is not present. A list of said delegate volunteers will be made available to parents. By signing this acknowledgement, I/we understand that the Califon Board of Education and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to a student via a pre-filled auto-injector mechanism.

_____ _____

♦ **Parent/Guardian Signature** **Date**

Parent Acknowledgement and Authorization if Student is Self-Administering

I/we the parents/guardians, of the above named student certify that he/she is capable of and has been instructed in the proper administration of the above named medication and authorize the above named student to self-administer the medication as identified above. By signing this acknowledgment, I/we understand that the Califon Board of Education and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by this pupil, and that we hereby indemnify and hold harmless the district, its employees or agents against any claims arising out of the self-administration of said medication by this pupil.

_____ _____

♦ **Parent/Guardian Signature** **Date**

Student Acknowledgment and Authorization if Self-Administering

I, the above named student, acknowledge that I am capable of and have been instructed in the proper administration of the above named medication(s). I am also aware that I must immediately report to the school nurse or teacher if I suspect an allergen exposure, any signs of allergic reaction, or have used the above-prescribed medication(s).

_____ _____

♦ **Student's Signature** **Date**