Milltown School District

ALLERGY ACTION PLAN

SCHOOL YEAR 20____ TO 20____

Child's Photo

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: ____

ALLERGY To: _____

Asthmatic Yes* () No () *Higher risk for severe reaction

Location of epinephrine (check all that apply): _____ with student _____ with nurse _____ other_____

SECTION I-TREATMENT – To be completed by the physician/advanced practice nurse:

Symptoms (The severity of symptoms can quickly change!)		**Give Checked Medication**
If food allergen has been ingested or student has been stung by an insect		(To be determined by physician authorizing treatment)
(If order is for insect sting allergy), but **no symptoms**		() Epinephrine () Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	() Epinephrine () Antihistamine
Skin	Hives, itchy rash, swelling on face or extremities	() Epinephrine () Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	() Epinephrine () Antihistamine
General	Panic, sudden fatigue, chills, fear of impending doom	() Epinephrine () Antihistamine
Throat †	Tightening of throat, hoarseness, hacking cough	() Epinephrine () Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	() Epinephrine () Antihistamine
Heart †	Thready pulse, passing out, fainting, pale, blueness	() Epinephrine () Antihistamine
Other † _____		() Epinephrine () Antihistamine
If reaction is progressing (several of the above areas affected) †		() Epinephrine () Antihistamine

† *Potentially life threatening*

DOSAGE

Epinephrine: (Inject intramuscularly, outer thigh) Brand_____ Dosage_____

Epinephrine may be repeated in _____minutes

Antihistamine: give_____

Medication/dose/route

Other: give _____

Medication/dose/route

CALL 911- state "a student had a severe allergic reaction, and additional epinephrine may be needed! Please send paramedics". Student must be transported to the nearest hospital even if the student's symptoms appear to have resolved. Then call parents.

TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT (Please check one answer):

N.J.S.A. 18A:40-12.6 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine to a student who has anaphylaxis when a nurse is not physically present at the scene.

_____ **Delegate Order- For suspected exposure to allergen(s) listed above**, delegates are to immediately administer prescribed auto-inject epinephrine. (Note: Delegates will not be able to administer an antihistamine as the first treatment)

_____ **This student's order should not be delegated**

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Please check all that apply):

N.J.S.A. 18A:40-12.3 directs that a student may be permitted to self-administer medications for potentially life threatening illness provided proper procedures are followed.

_____ This student has a potentially life-threatening allergy and will carry epinephrine at all times in school or when attending a School-sponsored event.

_____ This student understands, has been instructed, and is capable of the proper technique of self administration of the prescribed medication(s).

_____ This student is aware that he/she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to an adult immediately.

Physician Signature: _____ Date: _____

Physician Stamp:

(complete other side)

ALLERGY ACTION PLAN

SECTION II- To be completed by Parent/Guardian/Adult Student:

_____, a student in the Milltown School District has a potentially life-threatening allergy that could result in anaphylaxis. This student requires emergency administration of epinephrine by a pre-filled single dose auto-injector mechanism containing epinephrine in the event of anaphylaxis

In order to keep the student safe at school or a school sponsored event, I consent to the following for the 20____/20____ school year:

A. Authorization for Administration of Medication

I hereby give permission for the student named above to receive medication at school as prescribed above. I will contact the school nurse with any questions or changes in the student's health condition.

Parent/Guardian Signature _____ Date _____

B. Authorization for Release of Medical Information

I give permission for the release and exchange of information between the school nurse and the student's health care provider concerning the student's health and medications. I give permission for the school nurse to share this medical information with members of the school staff who have direct responsibility for the student in school or at a school sponsored event.

Parent/Guardian/Adult Student Signature _____ Date _____

C. Authorization for the Administration of Epinephrine By Nurse or Designees/Delegates

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the certified school nurse or a delegate/designee trained by the school nurse to administer epinephrine in the event the school nurse in not present at the scene. I understand that the Milltown Board of Education and its employees shall have no liability as a result of any injury arising from the administration of epinephrine via a pre-filled auto-injector mechanism to the student named above. I shall indemnify and hold harmless the Milltown Board of Education and its employees or agents against any claims arising out of the administration of epinephrine to the student via a pre-filled auto-injector mechanism.

Parent/Guardian/Adult Student Signature _____ Date _____

D. Authorization for Student Self Administration of Medication

I give my permission for the student to carry and self-administer the prescribed medication. I will remind the student to have the medication with them at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre- measured dose of antihistamine, in its original labeled container, is to be kept with the student, along with the epinephrine, at all times. Extra medication will be sent to school to be kept in the Health Office in case the student forgets to bring the medication prescribed to school. The 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 allergen, any signs of allergic reaction, or has used medication. I understand that the Milltown Board of Education and its employees or agents shall incur no liability as a result of any injury arising from the self-administration by the student of the medication prescribed on this form and that I shall indemnify and hold harmless the Milltown Board of Education and its employees or agents against any claims arising out of the self-administration of medication by the student.

Parent/Guardian/Adult Student Signature _____ Date _____

Emergency contacts – Name/Relationship (List parent/guardians first) – Telephone numbers

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

(complete other side)