SOUTH BRUNSWICK BOARD OF EDUCATION

Emergency Health Care Plan and Medication Orders for Life Threatening Allergies – Grades 6-12

Student Name: _____ Date of Birth: _____ School year:_____

School: _____ Grade: _____ Unit/Teacher:_____

Allergy to: _____ **Asthma: ____Yes / No_____**

____STEP 1: TREATMENT – <u>to be completed by Physician</u>

Symptoms:	**Give Checked Medication** (to be determined by physician)	
If exposure to an allergen occurs, but *no symptoms*	☐ **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* Tightening of throat, hoarseness, hacking cough**	☐ **Epinephrine**	☐ **Antihistamine**
• **Lungs* Shortness of breath, repetitive coughing, wheezing**	☐ **Epinephrine**	☐ **Antihistamine**
• **Heart* Weak or thready pulse, low blood pressure, fainting, pale, blueness**	☐ **Epinephrine**	☐ **Antihistamine**
• **Other*** _____	☐ **Epinephrine**	☐ **Antihistamine**
• **If reaction is progressing (several of the above areas affected), give:**	☐ **Epinephrine**	☐ **Antihistamine**

* Potentially life-threatening. The severity of symptoms can quickly change.

<u>DOSAGE:</u>

Epinephrine – prefilled auto-inject intramuscularly **(circle one): Epi-Pen 0.3mg / Epi-Pen Jr. 0.15mg**

Antihistamine - give (medication/dose): **____Benadryl_____mg_____**

Repeat Epinephrine prefilled auto injector _____Yes_____/_____No_____ in 15 minutes if squad has not arrived - 2 kits will be needed in school.

STEP 2: EMERGENCY CALLS – <u>to be completed by Parent/Guardian</u>

1. **Call 911** for Rescue Squad and state that an allergic reaction has been treated

2. Call: Mother: Home: _____ Work: _____ Cell: _____

   Father: Home: _____Work: _____ Cell: _____

   Emergency Contacts:
   First: Name: _____ Relationship: _____ Number: _____

   Second: Name: _____ Relationship: _____ Number: _____

3 Physician _____ Phone:_____

4. Preferred Hospital _____ Phone:_____

SELF ADMINISTRATION

I understand and agree that the student requires the administration of epinephrine, or a unit dose of Benadryl *in conjunction with* epinephrine, when exposed to a specific allergen and is capable of self-administration and should carry their own emergency medications. **_____Yes_____/_____No_____.**

DESIGNEES

I understand that the school nurse, when available, is responsible for emergency care to the student. In the absence of the school nurse, the nurse can designate and train another staff member to administer pre-filled single dose auto-injectors of epinephrine as per this Emergency Health Care Plan. **__Yes__/__No___**.

Designees are not authorized to administer Benadryl.

CARRYING MEDICATION

I understand that I assume full responsibility to ensure that my child is carrying Epinephrine and Benadryl on any and all school trips.
Signature_____

BEFORE AND AFTER SCHOOL PROGRAM

This Emergency Health Care Plan and Medication Order may be used in the before and/or after school programs **__Yes___/___No___/__Not applicable__**.

I hereby acknowledge that the South Brunswick Board of Education, its agents and employees shall incur no liability as a result of any injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to the student, and agree to indemnify and hold harmless the district, its employees and its agents against any claims arising out of the administration of a pre-filled, single dose, auto-injector mechanism containing epinephrine.

Parent/Guardian Signature: _____ Date: ____

School Nurse's Signature: _____ Date: _____

Physician's Signature <u>and Stamp</u>: _____ Date: _____