W.O. Krumbiegel Middle School

HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name: _____ Grade/Teacher/HmRm_____

The above student is allergic to: _____

Asthmatic ☐ Yes ☐ No

MEDICATIONS

PLEASE NOTE: The School Nurse by law may administer any medication with physician's orders and parental consent, but trained non-medical designees, who may give emergency treatment in the School Nurse's absence, are NOT permitted by law to administer any medications other than epinephrine via auto-injector mechanism.

☐ EPINEPHRINE: ☐ EpiPen ☐ EpiPen Jr. ☐ Other_____

School Nurse or designee: Give epinephrine for the following checked systems:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or blush skin
☐ Other: _____

After giving epinephrine, call 911, parent, and healthcare provider

Antihistamine: Medication_____ **Dose**_____

School Nurse only: Give antihistamine for the following checked symptoms:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or blush skin
☐ Other: _____

OTHER INSTRUCTIONS: _____

☐ This student has been trained and is authorized to self-administer the following medication(s) named above. ☐ epinephrine – single dose unit ☐ antihistamine – single dose unit

☐ This student is not authorized to self-administer the medication(s) named above.

Healthcare Provider's signature: _____ Healthcare Provider's phone #_____

Date: _____ Healthcare Provider's Stamp: _____

PARENT/GUARDIAN CONSENT

The school nurse at HILLSIDE HIGH SCHOOL has permission to administer the above medication to my child as prescribed by physician. I/we give permission to the school nurse to contact the physician if necessary. I/we also acknowledge that the district or its employees shall incur no liability as a result of the administration of the above medication or injury arising from the self administration of medication by the pupil and indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by my child.

Parent/Guardian Signature: _____ **Date:** _____

_____ **Date:** _____

Hillside Public Schools

Hillside, New Jersey 07205

Parental Consent for release of Confidential Information

and Delegation of Epinephrine by Auto-Injector

Student_____ School_____

Date of Birth_____ Grade_____

As the parent/guardian of the above named student, I hereby authorize the release of Pertinent medical information (medical condition, allergies and/or medication regime) to be exchanged among the appropriate professional staff involved in the care of my child.

I hereby give my consent to permit_____ as a designated person in an emergency to administer the epinephrine auto-injector to my child, _____, in the absence of the school nurse. I further agree to indemnify and hold harmless the Hillside Public School District and school employees from any claims arising from administration of epinephrine via auto-injector to my child. The consent and permission for the emergency administration of epinephrine via auto-injector to any student for anaphylaxis is effective for the school year in which it is granted and must be renewed for each subsequent school year. If my child's medical history changes, I will notify the school nurse.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Witness

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG — Short of breath, wheezing, repetitive cough

HEART — Pale, blue, faint, weak pulse, dizzy

THROAT — Tight, hoarse, trouble breathing/ swallowing

MOUTH — Significant swelling of the tongue and/or lips

SKIN — Many hives over body, widespread redness

GUT — Repetitive vomiting or severe diarrhea

OTHER — Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

⇩ ⇩ ⇩

Call 911. Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE — Itchy/runny nose, sneezing

MOUTH — Itchy mouth

SKIN — A few hives, mild itch

GUT — Mild nausea/discomfort

⇩ ⇩ ⇩

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

OTHER DIRECTIONS/INFORMATION

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

**For Antihistamine if physician want an antihistamine

HILLSIDE PUBLIC SCHOOLS
HILLSIDE, NEW JERSEY 07205

PART I REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL

NAME OF STUDENT: _____ GRADE _____ DOB: _____

ADDRESS: _____

NAME OF PARENT(S)/GUARDIAN: _____

EMERGENCY TELEPHONE NUMBERS - #1 _____ #2 _____

PLEASE NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE APPROPRIATE LABEL ATTACHED

PART II

NAME OF MEDICATION: _____

Dosage to be given: _____

Time to be given/Circumstances of Administration: _____

Duration: _____

Purpose/Diagnosis: _____

Restrictions: Physical Education Yes ☐ No ☐

If no, how long? _____

OTHER RESTRICTIONS: _____

Physician's Name (Please Print): _____

Address: _____

Telephone Number: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

PART III

PUPIL SELF ADMINISTRATION OF MEDICATION (PHYSICIAN'S CERTIFICATION)

I certify that the above named pupil is capable of and has been instructed in the proper use/method of administration and must be in possession of medication (as described above) at all times.

PHYSICIAN'S SIGNATURE: _____ Date: _____

PART IV

PARENT/GUARDIAN CONSENT

The school nurse at the Walter O. Krumbiegel Middle School has permission to administer the above medication to my child as prescribed by physician. I/we have given permission to the school nurse to contact the physician if necessary. I/we also acknowledge that the district or its employees shall incur no liability as a result of the administration of the above medication or injury arising from the self administration of medication by the pupil and indemnify and hold harmless the district and its employees or agents any claims arising out of the self-administration of medication by my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

_____ DATE: _____

HILLSIDE PUBLIC SCHOOLS
HILLSIDE, NEW JERSEY 07205

ART I REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL

NAME OF STUDENT: _____ GRADE _____ DOB: _____

ADDRESS: _____

NAME OF PARENT(S)/GUARDIAN: _____

EMERGENCY TELEPHONE NUMBERS - #1 _____ #2 _____

PLEASE NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE APPROPRIATE LABEL ATTACHED

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NAME OF MEDICATION: _____

Dosage to be given: _____

Time to be given/Circumstances of Administration: _____

Duration: _____

Purpose/Diagnosis: _____

Restrictions: Physical Education Yes ☐ No ☐

If no, how long? _____

OTHER RESTRICTIONS: _____

Physician's Name (Please Print): _____

Address: _____

Telephone Number: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

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PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DATE:

Physician's Signature_____ **Parent's Signature**_____ **School Year**_____

Individualized Care Plan for Student with possible Anaphylaxis

Name_____ Parent_____ DOB_____
Address_____ Contact Number_____ Teacher_____

Assessment	Nursing Dx.	Goals	Interventions	Outcomes	Evaluations
Parent has provided Medication and required health forms for use at school.	Potential for alteration in respiratory function	Student avoids anaphylactic triggers	Student identifies - triggers for anaphylaxis -symptoms of anaphylaxis	The student consistently avoid food triggers. Selects snacks from choices parent provides.	The student has no episodes of anaphylaxis
Student required EpiPen to avoid anaphylactic reaction previously Yes No	Potential for decreased cardiac output, hypotensive shock, vascular collapse	Student has emergency care available during the school day.	Student verbalizes understanding of how to administer the EpiPen and understands possible side effects of medication	The student reports to the school nurse if accidently exposed an anaphylaxis trigger.	Fieldtrip forms are consistently used
			Notify Food Service staff of students food allergy		Parent comes for medication at end of school year
			Provide school staff with emergency action plan for student		
			Staff will complete field trip forms for all class trips off campus		
			The student will have an EpiPen delegate to administer medications a backup to the school nurse		
			Access to EpiPen is available for staff		
			Reminders not to share food posted in the health room		