AUDUBON SCHOOL DISTRICT HEALTHCARE PROVIDER'S ORDERS
FOR ALLERGY EMERGENCY TREATMENT

Student's Name:_____Date of Birth:_____

The above student is allergic to: _____

Known Triggers: ☐ Ingestion ☐ Touch ☐ Sting ☐ Other (list):_____

Symptoms of allergic response/reaction: _____

Date of allergen testing: _____ ☐ Skin ☐ Blood ☐ Other (list):_____

This student has a history of an anaphylactic reaction: ☐ Yes ☐ No
If yes, date of reaction: _____ Treatment provided: _____
Facility ☐ ER ☐ Outpatient ☐ Hospital

Asthmatic: ☐ Yes ☐ No

PLEASE NOTE: The School Nurse by law may administer any medication with health care provider'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.

ORAL MEDICATION ORDER:

☐ Antihistamine (specify):_____

DOSAGE AND ROUTE OF ADMINISTRATION:_____
POSSIBLE SIDE EFFECTS: _____
OTHER INSTRUCTIONS:_____

Give medication for the following checked symptoms:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash
☐ Lips – itching, tingling, burning
☐ Other symptoms (list):_____
☐ After Epinephrine Auto-Injector is given

EPINEPHRINE AUTO-INJECTOR ORDER:

☐ EpiPen (0.3 mg) ☐ EpiPen Jr. (0.15mg) ☐ Other (specify):_____

DOSAGE AND ROUTE OF ADMINISTRATION:_____
POSSIBLE SIDE EFFECTS:_____
OTHER INSTRUCTIONS :_____

Give medication for the following checked symptoms:

☐ Lips –swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat, difficulty swallowing
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, stridor, shortness of breath, difficulty breathing
☐ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin, loss of consciousness
☐ Other symptoms: (list):_____

☐ This student has been instructed in proper administration of single dose units of the medication(s) named above and is competent to self administer.
☐ This student is **not** capable or authorized to self-administer single dose unit of the medication(s) named above.

Healthcare Provider's signature: _____Date: _____
Healthcare Provider's telephone: _____Healthcare Provider's Stamp:

AUDUBON SCHOOL DISTRICT - PARENT/GUARDIAN CONSENT FOR ALLERGY EMERGENCY TREATMENT

My child, _____, requires the administration of epinephrine in case of an anaphylactic reaction. I understand that I must submit to the School Nurse written orders from a healthcare provider, indicating that my child requires the administration of the medication. I further understand that I must provide the school with 2 current epinephrine pre-filled auto-injectors, that I am responsible for replacing them when they expire or have been used, and that I shall pick them up at the end of the school year or the end of the period of medication. My permission is effective for the school year for which it is granted. I understand that it must be renewed for each subsequent school year.

I understand that the School Nurse will be available during school hours and may be available at school-sponsored events in case of an allergic reaction. The trained designee, if appointed, will be available during school hours and at school-sponsored events. I realize that it is my responsibility to inform the nurse in a timely manner of the school-sponsored events in which my child will participate. I further understand that designees may be assigned to students who are qualified to self-administer their emergency medications, as well as to those who are not qualified to self-administer. In the event that I decline to have a designee appointed, I also understand that there may not be a nurse at every school-sponsored event occurring outside the school day.

My child will self-administer a single dose unit of medication **ONLY** after a healthcare provider certifies that my child has a potentially life-threatening allergy, is capable of, and has been instructed in the proper method of self-administration, pursuant to N.J.S.A. 18A:40-12.3 and 12.4. Students permitted to carry and self administer their own epinephrine are also entitled to a delegate.

If my child should suffer an anaphylactic reaction and neither the school nurse nor the delegate is available, the emergency medical system will be activated by dialing 9-1-1.

Pursuant to N.J.S.A. 18A:40-12.5, I acknowledge my understanding that the Audubon School District, its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to my child, and I indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine to my child.

PARENTAL PERMISSION/AUTHORIZATION

☐ I grant permission and authorize the School Nurse to administer emergency medications as ordered by healthcare provider to treat my child for an allergic reaction or anaphylaxis.

Parent/Guardian Signature: _____ *Date:* _____

PARENTAL PERMISSION/AUTHORIZATION FOR DELEGATE

☐ I authorize the School Nurse to designate and train one or more employees of the Audubon School District to administer epinephrine via pre-filled auto-injector mechanism to my child in case of emergency, when the School Nurse is not present. I understand that no other medications, such as antihistamines, may be administered by the designee, and that the epinephrine via pre-filled auto-injector mechanism will be administered by the designee according to the orders provided by my child's Healthcare Provider.

☐ I DO NOT authorize the School Nurse to designate one or more employees of the Audubon School District to administer epinephrine via pre-filled-auto-injector mechanism to our child. We understand that a nurse may not be available during school-sponsored events.

Parent/Guardian Signature: _____ *Date:* _____

AUDUBON SCHOOL DISTRICT - THE ROLE OF THE PARENT/GUARDIAN

of student requiring the administration of epinephrine in case of an anaphylactic reaction

1. The parent(s)/guardian(s) must provide the school with written statement from their physician or advanced practice nurse that the pupil's allergies may require the administration of epinephrine for anaphylaxis.

2. Provide physician's medication order, directions, and consent for administration with the understanding that the district shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto injector mechanism containing epinephrine.

3. Provide properly labeled medication(s) and promptly replace medication after use or upon expiration. 2 units Epinephrine via Auto-Injector must be provided; one will be kept in the Health Office and the other will be kept in an unlocked, secure location as per N.J. S.A. 18A 40-12.6.

4. Educate the child in the self-management of their food allergy including:

    - safe and unsafe foods;
    - strategies for avoiding exposure to unsafe foods;
    - symptoms of allergic reactions;
    - how and when to tell an adult they may be having an allergy-related problem; and
    - how to read food labels (age appropriate)

5. Work with the school team, as per student needs, to develop a plan that accommodates the student throughout the school, including the classroom, K.E.Y.S. program, and school sponsored activities.

6. It is understood that the parents/guardians have the responsibility to inform the school nurse in a timely manner of the school sponsored events in which their child will participate and in which the parent is not in attendance.

7. Provide current emergency contact information and update regularly.

Parent/Guardian Name (Printed)_____Signature_____Date_____