BORDENTOWN REGIONAL SCHOOL DISTRICT
School Health Services

Bordentown Regional HS
318 Ward Avenue
Bordentown, NJ 08505
(609) 298-0025 x1109
Fax (609) 291-0347

Bordentown Regional MS
50 Dunns Mill Road
Bordentown, NJ 08505
(609) 298-0674 x2009

MacFarland IS
87 Crosswicks Street
Bordentown, NJ 08505
(609) 291-7192 x5110

Peter Muschal ES
323 Ward Avenue
Bordentown, NJ 08505
(609) 298-2600 x4109

Clara Barton ES
100 Crosswicks Street
Bordentown, NJ 08505
(609) 298-0676 x3109

Epinephrine Auto Injection Administration Order

Student's Name: ______________________________ Date: Begin: ________ End: ________

To be completed by Private Health Care Provider:

Specific Allergen(s):____

Reaction to allergen occurs if, *(please circle all that apply)*:

Contact Ingestion Inhalation All of the above Other________________

____ I certify that this student has experienced Anaphylaxis and requires administration of an epinephrine auto injector after exposure to the specified allergen.

____ No known anaphylactic reaction - please explain reason epinephrine is ordered ___________
____

Self Administration (requires Physician's, School Nurse's, and Parent's Signature below):

____ I verify that __________________ has been adequately trained and is capable of self-administering the medication listed below in a life threatening situation.

____ Student **not** capable of self-administering

Physician's signature: ______________________ **School Nurse's Signature:** ________________
Parent Signature: ________________________

*****Name and dosage of epinephrine medication (Auto injector):**

_____For over 66 lbs. ____Epinephrine auto injector (0.3mg) _____ Auvi-Q 0.3mg

_____For under 66 lbs. ____Epinephrine auto injector (0.15mg) _____ Auvi-Q 0.15mg

Side Effects: ____

***** Name and dosage of Antihistamine:**
Antihistamine name ___________________________Dosage _____________ Route___________

Check One _____ give antihistamine first & monitor _____ give simultaneously with epinephrine
****According to NJ state law, when nurse is not physically present→trained designee will give epinephrine only. Any antihistamine order will be disregarded. ****

Physician's Signature: ________________________________ **Date:**________________

Printed Physician's Name: ____________________________ **Phone:**________________
Office Stamp

OVER→

Student's Name ________________________________

Lunchroom Accommodations – Doctor initial appropriate intervention

______No special seating ______Seat at a separate table. ______Unable to eat in lunchroom

To be completed by Parent/Guardian:

Delegation: (initial)

_________If the nurse is unavailable; a **delegate** **is permitted** to administer Epinephrine.

_________If the nurse is unavailable; a **delegate** **is not permitted** to administer Epinephrine.

The following individual(s) have been trained to administer epinephrine auto-injector:

____

____

I acknowledge that the Bordentown Regional School District and its employees or agents shall incur no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to my child. I indemnify and hold harmless the Bordentown Regional School District and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to my child.

Parent/guardian Signature____________________________________ Date____________