



# Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

The New Jersey Department of Education has implemented NJ Public Law 2007, Chapter 57. This law includes specific language pertaining to the administration of epinephrine to students. Any student whose physician orders epinephrine for anaphylaxis shall be offered a volunteer, non-medical designee to administer epinephrine via a pre-filled auto-injector mechanism when the school nurse is unavailable. This also pertains to those students who are capable of and have self-medication orders.

Please review the enclosed forms and discuss them with your child's physician. All completed forms should be returned to your child's school nurse.

Pre-filled auto-injector mechanism(s) are to be supplied to the school nurse in a properly labeled container, with the child's name, dosage, etc., on the pharmacist's label. If you are requesting a designee, a minimum of two injectors are required. Also, please notify the school nurse in writing of any school sponsored activities in which your child will be participating so that plans can be made for his/her safety.

If you have any questions, please contact your child's school nurse.

Sincerely,

*Patricia A. Callander*

Patricia Callander  
Assistant Superintendent/Pupil Services

PC:mk

Enclosures: Parent Request/Refusal for Pre-filled Auto-Injector Mechanism  
Administration When Nurse is Unavailable/Hold Harmless  
Medication Order Sheets (2)  
Self-Medication Order Sheet (2)  
Food Allergy & Anaphylaxis Emergency Care Plan  
Bus Transport Emergency Medical Plan  
Individualized Emergency HealthCare Plan



# Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

## Parent Request for Pre-filled Auto-Injector Mechanism (EpiPen) Administration When Nurse is Unavailable

Student's Name \_\_\_\_\_ School \_\_\_\_\_

I give permission for a trained, delegated, nonmedical person (delegate) to administer epinephrine via pre-filled auto-injector mechanism to my child when needed and a nurse is not present. My child is allergic to \_\_\_\_\_.  
I understand that when epinephrine is administered to my child, 911 will be called and EMS will transport my child to the hospital.

I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising out of, or connected with, the administration of medication by a delegate.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

.....

## Parent Refusal for Pre-filled Auto-Injector Mechanism (EpiPen) Administration When Nurse is Unavailable

I waive my right to have a delegate administer prescribed epinephrine via pre-filled auto-injector mechanism to my child in the event of an exposure to a known life threatening allergen when a nurse is not present. I understand that 911 will be called immediately.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# Howell Township Public Schools

PROUD OF OUR SCHOOLS    CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

Should it be necessary for your child to receive medication during school hours, you must present **this form** or an order from your personal physician, stating medication, **dosage, time of administration**, and the length of time your child will be on medication. This includes Tylenol, Motrin, cough drops and **all** over-the-counter medications. Any changes in these directions must be verified by a call to the school nurse, as well as a written note from the physician.

Any dangerous condition being experienced by a child on medication should be spelled out in detail with procedures to follow should a reaction occur. **Medicine must be properly labeled and in the original container, with the child's name, dosage, etc., on the pharmacist's label. The parent/guardian must transport all medication to and from school, unless a child has a doctor's signed permission to self-medicate and therefore carry an emergency medication (inhaler, pre-filled auto-injector mechanism).**

Sincerely,

*Patricia A. Callander*

Patricia Callander  
Assistant Superintendent/Pupil Services

### Request for Administration of Medication

Student \_\_\_\_\_ Homeroom \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time of Administration \_\_\_\_\_

Daily or PRN: \_\_\_\_\_ to be given \_\_\_\_\_ minutes before physical education or recess

To begin on \_\_\_\_\_ and conclude on \_\_\_\_\_

Possible side effects to be observed: \_\_\_\_\_

Special Instructions \_\_\_\_\_

Is this medication needed during field trips?      Yes \_\_\_\_\_ No \_\_\_\_\_

Is this medication to be given on early dismissal day?    Yes \_\_\_\_\_ No \_\_\_\_\_

Is child on any other medication? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

School Physician's Approval \_\_\_\_\_

\_\_\_\_\_  
Signature of Principal/Approval

**PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.**



Physician's Stamp



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*Patricia A. Callander*

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Assistant Superintendent/Pupil Services

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Student \_\_\_\_\_ Homeroom \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time of Administration \_\_\_\_\_

Daily or PRN: \_\_\_\_\_ to be given \_\_\_\_\_ minutes before physical education or recess

To begin on \_\_\_\_\_ and conclude on \_\_\_\_\_

Possible side effects to be observed: \_\_\_\_\_

Special Instructions \_\_\_\_\_

Is this medication needed during field trips? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this medication to be given on early dismissal day? Yes \_\_\_\_\_ No \_\_\_\_\_

Is child on any other medication? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

School Physician's Approval \_\_\_\_\_

\_\_\_\_\_  
Signature of Principal/Approval

**PLEASE NOTE:** If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.



Physician's Stamp

Howell Township Public Schools  
**Permission to Self-Administer Emergency Medications**

Howell Township Board of Education Policy 508 allows for the self-administration of medication for potentially life-threatening conditions only. A life-threatening condition is a condition that requires an immediate response to specific symptoms that if left untreated may lead to potential loss of life, for example: adrenaline for anaphylaxis, inhalers for asthma. This medication order will remain in effect for the current school year. Please note it is the parent's responsibility to ensure that the medication carried by the child has not reached its expiration date.

\*\*\*\*\***Part I – To be completed by physician**\*\*\*\*\*

The student named below has a potentially life-threatening condition. This student has been instructed in the proper method of self-medication for this condition and is capable and responsible to self-administer.

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Potentially Life-Threatening Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Physician's Stamp

\*\*\*\*\***Part II – To be completed by parent/legal guardian**\*\*\*\*\*

I, as parent/guardian of \_\_\_\_\_, request the Howell Township Board of Education to permit my child to carry and self-administer the emergency medication as prescribed above by their physician. My child understands the proper use of this medication and will be responsible for it. I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising from the self-administration of medication.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

School Physician \_\_\_\_\_ Principal \_\_\_\_\_

Howell Township Public Schools  
**Permission to Self-Administer Emergency Medications**

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\*\*\*\*\***Part I – To be completed by physician**\*\*\*\*\*

The student named below has a potentially life-threatening condition. This student has been instructed in the proper method of self-medication for this condition and is capable and responsible to self-administer.

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Potentially Life-Threatening Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

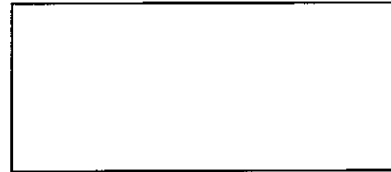
Additional Instructions: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Physician's Stamp

\*\*\*\*\***Part II – To be completed by parent/legal guardian**\*\*\*\*\*

I, as parent/guardian of \_\_\_\_\_, request the Howell Township Board of Education to permit my child to carry and self-administer the emergency medication as prescribed above by their physician. My child understands the proper use of this medication and will be responsible for it. I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising from the self-administration of medication.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

School Physician \_\_\_\_\_ Principal \_\_\_\_\_



Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

PLACE  
PICTURE  
HERE

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

## FOR ANY OF THE FOLLOWING: SEVERE 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, severe  
diarrhea



### OTHER

Feeling  
something bad is  
about to happen,  
anxiety, confusion

**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS



### NOSE

Itchy/runny  
nose,  
sneezing



### MOUTH

Itchy mouth



### SKIN

A few hives,  
mild itch



### GUT

Mild nausea/  
discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

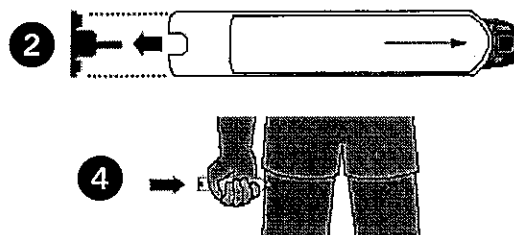
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_



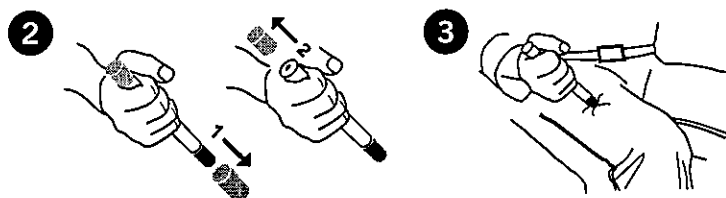
**EPIPEN® AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



**ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



**ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:**

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_





# Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

## BUS TRANSPORT EMERGENCY MEDICAL PLAN

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ROUTE #: \_\_\_\_\_

1. \_\_\_\_\_ has a history of severe allergy to \_\_\_\_\_

2. It can be so severe that **"anaphylaxis"** can occur.

**Anaphylaxis is a rapid, severe allergic response that occurs when a person is exposed to an allergy-causing substance. It is brought on when the allergen enters the bloodstream, causing the release of chemicals throughout the body that try to protect it from the foreign substance.**

3. Signs and symptoms of **"anaphylaxis"** include hives or rash, swelling of face and/or extremities, tingling of lips and mouth, a feeling of fullness in the throat, flushing of face or body, coughing, wheezing, shortness of breath, nausea, vomiting, abdominal cramps, diarrhea, increased heart rate, low blood pressure, fainting. Coma, respiratory and cardiac arrest can also occur.

4. If \_\_\_\_\_ shows any of the symptoms of anaphylaxis noted above:

- A. Radio for help. Ask for 911 emergency response to meet you at your location. Tell the dispatcher: "I am transporting a \_\_\_\_\_ year old child with a history of severe \_\_\_\_\_ allergy resulting in anaphylaxis. His/her symptoms are....."
- B. Stay with the child, speak calmly, reassure him/her that people are coming to help.
- C. When \_\_\_\_\_ is to be transported to the hospital, send this form with emergency telephone numbers with him/her.
- D. Make sure that your bus company contacts the parents and the school to explain the reaction and to which hospital the child has been transported.
- E. Fill out the attached accident/incident report, make a copy for your files, and drop the completed form off at school.
- F. If you have any questions, please contact the school nurse at \_\_\_\_\_. Also, please keep in close communication with me throughout the year with any changes that may occur with the bus run as the year progresses.

5. The student will be seated at the front of the bus to the right of the bus driver. \_\_\_\_\_  
*Accept Decline*

\_\_\_\_\_  
Certified School Nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Bus Driver

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

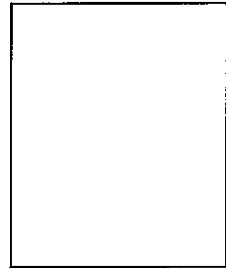
\_\_\_\_\_  
Date

### EMERGENCY CONTACTS

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

**HOWELL TOWNSHIP SCHOOL DISTRICT  
INDIVIDUALIZED EMERGENCY HEALTHCARE PLAN for STUDENTS  
WITH SEVERE ALLERGIES**



Student: \_\_\_\_\_ Teacher: \_\_\_\_\_ Date: \_\_\_\_\_  
**Severe allergy to:** \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Preferred hospital in case of emergency: \_\_\_\_\_  
 Epinephrine delegate(s): Yes \_\_\_ No: \_\_\_  
 Name of delegate(s): \_\_\_\_\_  
 Location of Epinephrine: **Main Office/ Health Office/ Student Carries**

**CONTACT INFORMATION**

<b>Parent /Guardian:</b>	<b>Home Phone:</b> _____
1. _____	<b>Work:</b> _____
2. _____	<b>Cell:</b> _____
	<b>Work:</b> _____
	<b>Cell:</b> _____
<b>Emergency Contact:</b>	<b>Home Phone:</b> _____
	<b>Work:</b> _____
	<b>Cell:</b> _____

**Previous Reaction:** \_\_\_\_\_

**STUDENT -SPECIFIC EMERGENCIES**

<i>If you see any of these signs or symptoms of an allergic reaction</i>	<i>Do This</i>
<b>Mouth-</b> Itching & swelling of lips, tongue, or mouth	1. If student presents with any of these signs or symptoms, notify nurse immediately@ _____ and Main Office @ _____. If nurse is unavailable, call 911 immediately and contact delegate if indicated above.*
<b>Throat-</b> Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough, choking	2. Student has order for _____ mg Benadryl: Yes ___ No ___ Student carries Benadryl: Yes ___ No ___ Benadryl kept in Health Office: Yes ___ No ___ Student may self administer epinephrine: Yes ___ No ___ Epinephrine _____ mg to be administered Dose may be repeated: Yes ___ No ___
<b>Skin-</b> Hives, itchy rash, and/or swelling about the face or extremities, flushed face	3. Note and Record: Time of Incident: _____ Time of Administration of Epinephrine and site: _____ Circumstances (where and what was the allergen): _____ Contact parent. Remain with student.
<b>Gut-</b> Nausea, abdominal cramps, vomiting, and/or diarrhea	4. Student must be transported to hospital if epinephrine is administered.
<b>Lung-</b> Shortness of breath, repetitive coughing, and/or wheezing	
<b>Heart-</b> "Thready" pulse, "passing-out", rapid heart rate	*For After School Activities Activate EMS 911. Notify administrator or site supervisor who will contact delegate if in building.
<b>Other-</b> Dizziness, unsteadiness, sudden fatigue, chills, loss of Consciousness	*Parent to notify nurse if student is staying after school.

**If an emergency occurs:**

1. If the emergency is life-threatening, immediately call 9-1-1 and request Advanced Life Support. .
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or the school nurse.

State who you are, where you are and the problem.

School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Copy to: \_\_\_\_\_