

**SPOTSWOOD SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT**

Student's name _____ Birth date _____ Grade/teacher _____

The above student is allergic to: _____

Previous episode of anaphylaxis Yes No

MEDICATIONS

ANTIHISTAMINE: Name _____ Dose _____

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 bluish skin
- Other _____

EPINEPHRINE: EpiPen EpiPen Jr. Other _____

Give epinephrine 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 bluish skin
- Other _____

Choose one administration order:

Give Antihistamine only Give epinephrine only *Delegate will be assigned

Give Antihistamine & Epinephrine at same time *Delegate will be assigned

Give Antihistamine first, observe for further symptoms and give epinephrine PRN

***Please note- in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

This student has been trained and is capable of self-administration of the following medication(s) named above. epinephrine – single dose unit Epinephrine & antihistamine – single dose units

*Under NJ state law, orders for antihistamine alone cannot be self administered

This student is not capable of self-administration of the medications named above.

Physician's signature _____

Phone number _____

Date _____

Stamp _____

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container

Select one to sign and date.

1. I verify that my child _____ has a potentially life threatening illness and **has been instructed in self- administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self administer prescribed medication.** I further acknowledge that the Spotswood School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by NJ law and Spotswood School District policy are followed, I shall indemnify and hold harmless the Spotswood School District and it's employees or agents against any claims arising out of self administration of medication by my child.

Signature of Parent/Guardian

Date

2. I verify that my child _____ has a potentially life threatening illness and is **unable to self-administer** the prescribed medication in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Spotswood School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Spotswood School District Policy are followed, I shall indemnify and hold harmless the Spotswood School District and it's employees or agents against any claims arising out of administration of medication to my child.

Signature of Parent/Guardian

Date

Please sign

I understand that under NJ state law, a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

Parent Signature

Date

SCHOOL USE ONLY

Signature of Principal

Date

Signature of School Nurse

Date