New Milford Schools

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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**

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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.

**This Physician/Parent consent order is effective for 09-10 school year only, and must be renewed each school year.**

Physician’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Parents/Guardians

#### Two current single dose Epinephrine auto-injectors 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 the prescribed medication**. I further acknowledge that the New Milford 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 the New Milford School District policy are followed, I shall indemnify and hold harmless the New Milford School District and it’s employees or agents against any claims arising out of self administration of medication by my child.

**This Physician/Parent consent order is effective for \_\_\_\_\_ school year only, and must be renewed each school year.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 New Milford 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 the New Milford School District Policy are followed, I shall indemnify and hold harmless the New Milford School District and it’s employees or agents against any claims arising out of administration of medication to my child.

**This Physician/Parent consent order is effective for \_\_\_\_\_ school year only, and must be renewed each school year.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date

**SCHOOL USE ONLY**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Principal Date Signature of School Nurse Date