SCOTCH PLAINS-FANWOOD SCHOOL DISTRICT
MEDICAL ORDERS AND EMERGENCY HEALTH CARE PLAN FOR SIGNIFICANT ALLERGIC REACTIONS

Student's Name Date of Birth Grade/Teacher

Place Student's Picture Here

PHYSICIAN'S ORDERS & INSTRUCTIONS:

SEVERE ALLERGY TO: _____

Student's known symptoms: _____

Is the student asthmatic? Yes* _____ No_____ (* High risk for severe reaction)

SECTION 1: MEDICAL ORDERS FOR TREATMENT

CHECK THE APPROPRIATE BOX BELOW:

- ❑ Give antihistamine immediately after suspected contact with, or ingestion of, allergen and follow with epinephrine if symptoms progress to severe.
- ❑ Give epinephrine **only** immediately after suspected contact with, or ingestion of, allergen regardless of presenting symptoms.

Mild Symptoms Only: Mouth: Itchy mouth Skin: A few hives around mouth/face, mild itch Gut: Mild nausea/discomfort	→	**Give antihistamine** • Student may self administer if age appropriate. • Stay with student. Contact parent for transport home. • If symptoms progress, administer the epinephrine and call 911.
Severe Symptoms: One or more of the following symptoms are present or a combination of symptoms from different body systems: Lung: Short of breath, wheezing, repetitive cough Heart: Pale, blue, feels faint, weak pulse, dizzy, confused Throat: Tight, hoarse, trouble breathing or swallowing Mouth: Obstructive swelling of tongue or lips Skin: Hives, itchy rash, swelling of face or eyes Gut: Vomiting, diarrhea, cramping pain	→	**Inject epinephrine immediately** • Student may self administer if age appropriate. • Stay with student. • Call 911 and request the paramedics. Contact the parent. Student must be transported to the ER. • Position student for comfort and to aide breathing and prevent aspiration of vomited materials. • May repeat dose of epinephrine in 15 minutes if symptoms persist or worsen. • Document incident.

MEDICATION/DOSAGE:

Auto injectable Epinephrine Dose: (Circle): 0.15mg IM 0.3mg IM Other: _____

Antihistamine Dose: (Circle) : 12.5mg PO 25mg PO 50mg PO Every _____hours Other: _____

Other (oral steroid, inhaler-bronchodilator if asthmatic): _____

Possible side effects of medication: _____

Important: asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Conditions for administering medications: (check one)

- ❑ **Independently.** Student may be in possession of one dose of Benadryl and an auto-inject epinephrine and has been trained to self-administer. The student is aware that he/she may not share medication with anyone else. **The ability to self-administer is expected for High School students participating in after school activities since a delegate may not administer Benadryl. The nurse or delegate will assist the student, or intervene to administer the epinephrine, if needed.**
- ❑ **Administration only by the nurse or delegate.** (Not appropriate for HS students unless developmental/physical limits exist.)

_____ _____ _____ _____

Physician's Name/Stamp **Physician's Signature** **Phone** **Date**

TURN FORM OVER TO COMPLETE →

SECTION 2: EMERGENCY RESPONSE

1. Call the nurse **immediately** at ext. **3508** If the nurse is not available, contact the Main Office at ext**. 3407** to advise of the situation. Give the student's name, location and problem: **Severe allergic reaction**. (Call 911 if necessary)
2. Upon arrival, the school nurse or trained delegate will evaluate the student and administer the medication as per the physician's order (on page 1). Call 911 or delegate someone to do so. Asking for the paramedics to respond.
3. Calmly reassure student. Have student lie down to rest. If student becomes unconscious, assist to floor and position on side. Stay with student until help arrives.
4. Notify the parent/guardian
5. Any student receiving Epinephrine will be sent to the nearest hospital even if the parent cannot be reached. The used Auto injector should be given to the paramedics/rescue squad for disposal. Document time epinephrine was given.

SECTION 3: PARENT PERMISSION

I give permission for my child to be treated for a severe allergic reaction and, if age appropriate (grades 5-12) and doctor approved, to carry and self-administer the medication prescribed while on school property or off school property at an approved school event. In addition, I give permission for my child's athletic coach/club advisor/music director/teacher to serve as the trained epinephrine delegate for my child during after school and weekend activities, or during field trips when the school nurse is not present.

I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. A duplicate of this medication should be sent into the school in the original pharmacy labeled container and kept in an available location for the nurse and delegate

I understand that this contract is to be reviewed annually at the beginning of each school year. Permission to self-administer this medication shall not be construed as permission to self-administer other medication.

I hereby release and hold harmless the Scotch Plains-Fanwood Board of Education, its agents, servants and employees from any and all liability for damages that may result to the student, his/her servants and representatives from claims arising from the diagnosis and treatment/administration of a pre-filled epinephrine auto-injector to my child.

Parent/Guardian Signature: _____**Date**_____
Contact phone numbers: Parent #1: _____ Parent #2: _____

SECTION 4: STUDENT CONTRACT

I understand that I will use this medication as directed by my physician. I will be responsible and discreet in using this
_____Antihistamine and/or auto injectable epinephrine_____ and should have this medicine readily accessible.
(name of medication)

I have been instructed how to self administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else. After each use I will notify the nurse. I understand that if I do not abide by these regulations I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of each school year.

Student's Signature: _____ **Date:** _____

SECTION 5: RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Please check off the appropriate boxes: Information documented on the Emergency Health Care Plan may be shared with the following:

- ❑ Posted as a *Medical Alert* on *Power School* for viewing by the staff. (teachers, counselor, CST case manager, principals, principal's designee)
- ❑ Pupil specific Instructional aides
- ❑ The Food Service vendor (food related allergy only)
- ❑ Transportation (for those students on the daily bus to and from school)
- ❑ Coaches, Club Advisor, Music Directors:
  List all after school activities here: _____
  _____

SECTION 6: AFTER SCHOOL ACTIVITIES

A copy of the Emergency Health Care Plan will be given to the coach/club advisor/music director when the nurse is notified of your child's participation. **It is the student's responsibility to have one dose of the oral antihistamine and an Auto Inject Epinephrine in his/her possession at all times for self-administration or use by the delegate**. The student must keep the medication in an easily accessible location (ie: purse, backpack, gym bag) and alert the delegate assigned to the after-school activity as to the exact location of the medication. The after-hours delegate **will not** be in possession of an extra dose. The coach/advisor/director will not be responsible for reminding the student to carry the Auto Inject Epinephrine/Antihistamine.

_____

Signature of Parent/Guardian Date