WEST ESSEX REGIONAL SCHOOLS

Life Threatening Allergy Action Plan

Part 1: To be completed by Physician

Student's Name:_____ D.O.B._____ Grade (in September)_____
ALLERGY TO:_____Previous episode of anaphylaxis: Yes_____No_____

Medical Diagnosis (CIRCLE)

Asthmatic: Yes * No (*Higher risk for severe reaction)

Symptoms: Give Checked Medication

* Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine ___Antihistamine____
* Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine ___Antihistamine ____
* Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine ___Antihistamine____
* Throat:^ Tightening of throat, hoarseness, hacking cough	Epinephrine ___Antihistamine ____
* Lung:^ Shortness of breath, repetitive coughing, wheezing	Epinephrine ___Antihistamine ____
* Heart:^ Thready pulse, low blood pressure, fainting, pale, cyanosis	Epinephrine ___Antihistamine ____

* Other _____

The severity of symptoms can quickly change. ^**All Above Symptoms Can Potentially Progress to a Life-Threatening Situation**

ACTION FOR A REACTION

Epinephrine: Epinephrine Auto injector 0.3mg_____ Auvi-Q 0.3mg_____ Neffy Intranasal Spray 2mg _____

Antihistamine: Circle one **Benadryl** **Zyrtec** **Claritin** **Allegra**
Dose _____(Must be in Milligrams) Route_____

Check all that apply:

_____ **Student has been trained in procedure and has been instructed in symptom recognition and may carry and self-administer Epinephrine and Antihistamine, according to N.J.S.A. 18A:40-12.3 Student may self-administer (circle one) with or without adult supervision.**

_____ **Antihistamine may be omitted from the above plan on a field trip in the absence of an authorized Licensed staff member and when student is not capable of self administering this. (Parent has option of accompanying child and administering this on field trip)**

_____**May administer a second dose of Epinephrine if symptoms persist while awaiting EMS.**

STEP 2: EMERGENCY CALLS

1. Call 911 (requesting paramedics). State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Call Dr. _____at _____
3. Call Emergency contacts as *listed on reverse side*.

Parent/Caregiver Signature:_____Date:_____

Doctor's Signature:_____Date:_____

OFFICE STAMP

ALL MEDICATION ORDERS EXPIRE ON THE LAST DAY OF THE SCHOOL YEAR, NEW ORDERS ARE REQUIRED EACH SEPTEMBER

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PART 2: To be completed by Parent/Guardian

Emergency Contacts:

Name/Relationship Phone Number(s):

a._____1._____2._____

b._____1._____2_____

A. Parent/Guardian Permission for School Nurse Administration of Medication

To be completed by Parent/Caregiver: I give my permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.
I disclaim all liability of the West Essex Board of Education as it concerns the use of this medication.
I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.

_____ _____

Parent/Caregiver Signature Date

B. Parent/Guardian Permission for Self-Administration of Epi-Pen and/or Benadryl

To be completed by Parent/Caregiver: I give my permission for my child to self-administer the medication **as described on the reverse side**. I will notify the school nurse immediately if this medication is no longer directed by the physician.
I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self administration of medication by the pupil.
I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.

_____ _____

Parent/Guardian Signature Date

C. Student Agreement for Self-Administration

To be completed by the student: I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. 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.
I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication. I disclaim all liability of the West Essex Board of Education as it concerns my use of this medication.

_____ _____

Student's Signature Date

D.Treatment by Delegate When Nurse Not Present

NJ State Assembly Act Senate No. 79 directs that the school nurse shall designate additional employees of the school district who volunteer to administer a one time dose of epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene. I give my permission for a delegate to be assigned to my child in the event a nurse, or myself are not present. I disclaim all liability of the West Essex Board of Education and its employees as it concerns the use of this medication.

_____ _____

Parent/Guardian Signature Date