Milford Public School

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ALLERGY ACTION PLAN and MEDICATION ORDERS

This form must be completed by a PHYSICIAN/ADVANCED PRACTICE NURSE AND PARENT ANNUALLY for any student requiring epinephrine while in school or at a school-sponsored event.

Student Name_____DOB_____Grade_____

School Year_____HomeroomTeacher_____

Section I: To be completed by physician/advanced practice nurse:

Allergens_____

Reactions in the past_____

Is this a potentially life-threatening allergic reaction? Yes ☐ No ☐

Does student require seating at an allergen-safe cafeteria table? Yes* ☐ No ☐

*If Yes, please specify allergen(s), i.e., peanut-free, milk-free, etc. _____

Is this student asthmatic? Yes ☐ (Note high risk of severe reaction in asthmatics.) No ☐

Symptoms	**Give Checked Medication** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, or student has been stung by insect (if order is for an insect sting allergy) but *no symptoms*:	□ Epinephrine	□ Antihistamine
• 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, blueness:	□ Epinephrine	□ Antihistamine
• Other*** _____	□ Epinephrine	□ Antihistamine
• If reaction is progressing (several of the above areas affected):	□ Epinephrine	□ Antihistamine

The severity of symptoms can quickly change! ***Potentially life-threatening.

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Dosage

Epinephrine: Inject intramuscularly (circle one)

Epi Pen	Epi Pen Jr.	Auvi-Q	Auvi-Q
0.3 mg	0.15 mg	0.3 mg	0.15 mg

Epinephrine may be repeated in _____ minutes.

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis!

Action for a MINOR reaction:

1) Give antihistamine as ordered above or other_____.
2) Call parents/guardians or emergency contacts.
3) Call Dr. _____ at _____.

Action for a MAJOR reaction:

If condition does not improve or symptoms progress:

1) Administer epinephrine as ordered above.
2) Call 911 and ask for advanced life support (paramedics).
3) Call parents/guardians or emergency contacts.
4) Notify physician.

*** NOTE: 911 must be called if epinephrine is administered, and the child must be transported to a medical facility, even if parent/guardian cannot be reached! ***

Physician/APN Signature: _____

Treatment by Delegate:

New Jersey law directs that the certified school nurse, in consultation with the school administration, may train and designate another employee of the school district to administer a pre-filled single dose auto-injector containing epinephrine when the school nurse is not physically present at the scene. In the absence of the school nurse, if this student has had suspected exposure to allergen(s) listed above and is showing symptoms of an allergic reaction, any antihistamine order should be disregarded and epinephrine administered by a trained delegate. Epinephrine may be repeated in _____ minutes if symptoms persist or recur.

Physician/APN Signature: _____

Self-Administration:

NJ State Assembly Act – 2600 directs that students may be permitted to self-administer medication for potentially life-threatening illnesses, provided proper procedures are followed. Please check the appropriate response:

A. This student understands the purpose, proper technique of administration and frequency of use of the medication prescribed above, and is capable of self-administration of the medication. Yes ☐ No ☐

B. This student is aware that he/she must immediately report to the school nurse or teacher if he/she has had suspected exposure/ingestion of allergen(s), has any signs of an allergic reaction, or has used antihistamine or epinephrine. Yes ☐ No ☐

C. This student may self-administer epinephrine and antihistamine as prescribed. Yes ☐ No ☐

Physician/APN Signature: _____

Date: _____

Please print or stamp name, address and phone.

_____
_____
_____
_____

Section II: To be completed by parent/guardian:

Parent Authorization (for ALL Students):

- I hereby give permission for my child, _____, to receive medication at school or at a school-sponsored event, as prescribed above.
- I understand that under New Jersey law, a trained delegate may administer epinephrine to my child in the absence of a school nurse. Since a delegate may not give antihistamines, in the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.
- I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child, and that parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to a student via a pre-filled auto-injector mechanism.
- I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications.
- I give permission for the school nurse to share this medical information with Milford Public School staff on a need-to-know basis.
- I will ensure that my child's epinephrine medication is provided to the Health Office. Diphenhydramine (Benadryl) need not be supplied to the Health Office.
- I will contact the school nurse with any questions or changes in my child's health condition.

Please check one:

☐ I ***DO*** request that my child be allowed to self-carry and self-administer the following medication(s): _____ for the _____ school year.

☐ I ***DO NOT*** request that my child self-carry and self-administer the following medication(s): _____ for the _____ school year.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Emergency contacts – Name/Relationship (List parent/guardians first) – Telephone numbers

1. _____ (H) _____ (C) _____ (W) _____
2. _____ (H) _____ (C) _____ (W) _____
3. _____ (H) _____ (C) _____ (W) _____

Parent Authorization (for Students with Physician Permission to Self-Administer Medication):

- I hereby give permission for my child, _____, to carry and self-administer medication as prescribed on this form for the current school year. I consider him/her to be responsible and capable of self-administration of the medication.

- I understand that the district and its employees shall have no liability as a result of any injury arising from the self-administration of medication by my child, and that parents and guardians 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 student.

- I will assure that the medication is in its original, labeled prescription container.

- I will remind my child to have the medication with him/her at all times.

- For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre-measured dose of antihistamine, in its original labeled container, is to be kept with the student, along with the epinephrine, at all times.

- Extra medication will be sent to school to be kept in the Health Office in case my child forgets to bring the prescribed medication to school.

- My child is aware that he/she must immediately report to the school nurse or teacher if he/she has had suspected exposure/ingestion of allergen(s), has any signs of an allergic reaction, or has used antihistamine or epinephrine.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____