Parent/Guardian Portion
Authorization for Administration of Epinephrine and Diphenhydramine in School

Section 4: Parent/Guardian permission. To be completed by parent/guarding of student. Complete and sign at bottom of page.

My child requires emergency administration of epinephrine by a pre-filled single- dose auto-injector in the event of anaphylaxis.

I consent to the following for the current school year:

___I will deliver the medication to the school nurse in its original prescription container labelled with child's name.

___I understand that it is my responsibility to ensure that the student always has the medication available at school.

___ I will be responsible for noting expiration date and replacing expired medication.

___ For students allowed to carry and self-administer: 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.

___I give permission for my child to receive medication at school as prescribed by my child's physician.

___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 members of the district staff who have direct responsibility for my child in school or at a school sponsored event.

___I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration of medication by the pupil and/or staff, and we, the parents or guardians, indemnify and hold harmless the school district and its employees or agents against any claims arising out of the administration or self-administration of medication by the pupil and/or staff. Any person who acts in good faith in accordance with the requirement of P.L. 2007, c 57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that section.

___I will contact the school nurse with any questions or changes in my child's health condition.

Parent/Guardian Signature: _____ **Date:** _____

Section 5: Designation of Administration of Epinephrine

The Certified School Nurse may designate, in consultation with the Building Administrator, another employee of the district to administer a pre-filled single dose auto-injector mechanism containing epinephrine when the school nurse is not physically present in the building or at the scene, if outside of school. Delegates are assigned according to activity- sports, activities & trips. The employee(s) are trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.

CHECK ONE ANSWER ONLY

_____ **I give consent** for a trained employee(s) of the district to administer epinephrine in the event the school nurse is not present at the scene. I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine, and that I indemnify and hold harmless the district and its employees or agents against any claims arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine.

_____I **do not give consent** for an employee to be designated as an epinephrine delegate for my child.

Student Self Administration

_____I allow my child to carry and self-administer epinephrine auto-injector, must be approved by physician also, on page 1.

_____I do not allow my child to carry and self-administer epinephrine auto-injector.

Parent/Guardian Signature: _____ **Date:** _____

Authorization for Administration of Epinephrine and Diphenhydramine in School

Directions: Please complete both sides of the form. This form is required annually for any student requiring administration of an Epinephrine Auto-Injector at school or a school sponsored event.

Student Name: _____ DOB: _____

School Year: _____ Grade: _____ **Student Picture:**

Wt. (lbs.): _____

Emergency Contacts – Name/Relationship (List Parent/Guardian First)

1. _____ Home _____ Cell _____ Work _____

2. _____ Home _____ Cell _____ Work _____

Section 1: To be completed by the Physician/Advanced Practice Nurse/Physician's Assistant

The Student's Potential triggers of Anaphylaxis are: _____
Does the student have Asthma? _____Yes _____No
The student's possible symptoms of Anaphylaxis are: _____
_____ or is currently unknown but is at risk of Anaphylaxis.
_____ Does the student require seating at an "allergy free" table during meals/snacks?
_____Yes _____ No _____Decision is up to the parent/guardian.

Section 2: Medication Orders

_____ Epinephrine auto-injector 0.3mg up to 2 doses as needed.
_____ Epinephrine auto-injector 0.15mg up to 2 doses as needed.
_____ School nurse may administer Diphenhydramine _____mg by mouth (single dose)
_____ Other: _____

Section 3: Student Self Administration Orders

NJ P.L. 2007, c57 directs that a student may be permitted to carry and self-administer Epinephrine by auto-injector at school and sponsored functions. The student must be properly trained in the carrying and use of the medication and approval is required by their medical provider and parent/guardian.

_____ This student **IS NOT** approved for self-carry and administration.
_____ This student **may self-carry and administer** their Epinephrine auto injector. Concurrence will be obtained by the student's parent/guardian and school nurse. This student understands the proper method of self-administration of their Epinephrine auto-injector.

_____ _____ _____
Medical Provider Signature Date: Phone Number

Office Stamp:

Documentation of Anaphylaxis Event and/or Epinephrine Administration

School District:_____ Name of School:_____

Student _____ Gender: M ☐ F ☐

Diagnosis/history of asthma: Yes ☐ No ☐

Date/Time of occurrence:_____ Known allergen(s):_____

Trigger that precipitated this allergic episode:_____

Initial Vital Signs: Pulse_____ Respiratory Rate:_____ BP_____

Skin or Mouth Itching/Rash: **Yes** ☐ **No** ☐

Nausea, Abdominal cramps or pain, vomiting: **Yes** ☐ **No** ☐

Shortness of breath, labored breathing, wheezing or stridor: **Yes** ☐ **No** ☐

Other Symptoms:_____

Location of student when symptoms developed:_____

Location of student when Epinephrine Auto-injector administered:_____

Epinephrine Auto-injector administered by: _____

First Dose: Location of injection: Right Thigh ☐ Left Thigh ☐
Dose: 0.3mg ☐ 0.15mg ☐
Time: _____

Second Dose: Location of injection: Right Thigh ☐ Left Thigh ☐
Dose: 0.3mg ☐ 0.15mg ☐
Time: _____

Antihistamine Administered? Yes ☐ No ☐ Name/Dose:_____ Time:_____

CPR performed: Yes ☐ No ☐

Approximate time between onset of symptoms and administration of Epinephrine:_____

Section completed by:_____ Date:_____
(please print)

Disposition:

Transferred to ER: Yes ☐ No ☐ Discharged after_____hours.

Hospitalized: Yes ☐ No ☐ Discharged after_____days.

Outcome:

_____

Recommendations for changes/improvements to current policy or procedures: Debriefing meeting? Yes ☐ No ☐

Section completed by:_____ Date:_____
(please print)