**NORTH BRUNSWICK TOWNSHIP SCHOOL DISTRICT**
**PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT**
**EMERGENCY HEALTH CARE PLAN**
## School Year

Student's name_____ Birth date_____ Grade/teacher _____

The above student is allergic to: _____

Previous episode of anaphylaxis : ☐ Yes ☐ No Asthma: ☐ Yes ☐ No

**MEDICATIONS**
**ANTIHISTAMINE**: Name _____ Dose _____

Give antihistamine for the following symptoms:_____

_____

**EPINEPHRINE AUTO INJECTOR**: ☐ (0.3mg) ☐ (0.15mg) ☐Other _____
☐ **Give repeat dose in 15 minutes if rescue squad has not arrived (2 autoinjectors will be needed)**

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 _____
**********

**Please note- in the absence of a school nurse, a trained delegate (if available) will give epinephrine and any antihistamine order will be disregarded**
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**SELECT ONE:**

☐ 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.

Physician's signature _____ Phone number _____

Date_____ Stamp _____

**Emergency Calls: (LIST PHONE NUMBERS)**
1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed

2. Mother:_____ Father:_____

3. Alternate Contact(1)_____ (2)_____

**I understand it is my responsibility to notify the School Nurse if my child is attending any school sponsored activities outside of the school day.**
_____**Parent Signature**

# Emergency Health Care Plan-Pg2

## Parents/Guardians

**A current single dose Epinepherine auto-injector must be provided to the school for your child's use(Two if second dose is ordered). All antihistamines and epinepherine 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 prescribed medication**. I further acknowledge that the North Brunswick Township 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 North Brunswick School District policy are followed, I shall indemnify and hold harmless the North Brunswick School District and it's employees or agents against any claims arising out of self administration of medication by my child.

_____ _____
Signature of Parent/Guardian Date

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

_____ _____
Signature of Parent/Guardian Date

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Please sign
I give my consent that, a trained delegate may administer epinephrine via a prefilled auto injector 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

**SCHOOL USE ONLY** **Location of Epinephrine Auto Injector**_____
_____Signature of School Nurse_____Date