



PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
- If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Short of breath, wheezing, repetitive cough



HEART

Pale, blue, faint, weak pulse, dizzy



THROAT

Tight, hoarse, trouble breathing/swallowing



MOUTH

Significant swelling of the tongue and/or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy/runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea/discomfort

FOR **MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS FROM A SINGLE SYSTEM AREA**, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

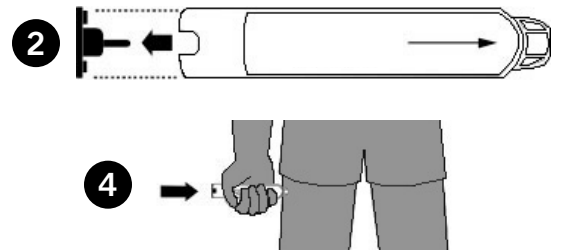
DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____

DATE _____

Monmouth County Vocational School District

PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY A STUDENT WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, _____ (print name of physician) certify that I am the physician of _____ (print name of student). This patient suffers from _____ (print name of illness), a potentially life-threatening illness/allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness/allergic reaction.

_____ (print name of student) is physically fit to attend school and is free of contagious disease **and** would not be able to attend school if the medication is not administered during school hours.

Name of Medication: _____

Dose and Route: _____

Time: _____

Side Effects: _____

Period of time to be administered: _____

Additional Instructions: _____

Signature of Physician/Stamp Telephone Date

Reviewed and approved by:

Signature of School Physician Date

Monmouth County Vocational School District

**SELF-MEDICATION PERMISSION FORM FOR A STUDENT WITH A
LIFE-THREATENING ILLNESS/ALLERGIC REACTION**

In accordance with P.L. 2007, c.57, this form must be signed by the parents or guardians of any student who wishes to self-administer and is capable of and has been instructed in the proper method of medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction.

We, _____ and _____ (print names of parents/guardians), are the parents or guardians of _____ (print name of student) a student in the Monmouth County Vocational School District. As required by law, this form provides to the Monmouth County Vocational School District Board of Education our written authorization for our child to self-administer medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction. By signing this form, we release the Monmouth County Vocational School District Board, its employees and agents, from any liability as a result of any injury from the self-administration of medication by our child and we expressly agree to defend, protect, indemnify, and hold harmless the Monmouth County Vocational School District, and its employees or agents, from all losses, costs, suits or claims which may result from the self-administration of medication by our child.

Attached to this form is the written certification of our physician verifying the diagnosis of my child as potentially life-threatening and the provision of medication instructions. Permission for our child to self-administer medication is effective upon approval and notification by the Monmouth County Vocational School District Board of Education. Permission remains effective only for the present school year.

Signature of Parent/Guardian

Date

Signature of School Physician

Date

Signature of School Nurse

Date

Signature of Principal

Date

MONMOUTH COUNTY VOCATIONAL SCHOOLS

CONSENT AND AUTHORIZATION FOR DELEGATION OF ADMINISTRATION OF MEDICATION

_____, has been designated by the school nurse in consultation with the Board of Education to administer epinephrine via pre-filled, single-dose auto-injector mechanism to _____ for anaphylaxis when the nurse is not physically present at the scene, in accordance with P.L 2007, c. 57.

This employee has been properly trained in the administration of epinephrine by the school nurse using standardized training protocols established by the Department of Education in consultation with the Department of Health and Human Services and has met the following criteria:

1. Is willing to learn and assume responsibility
2. Has demonstrated competency and good judgment
3. Holds a current CPR Providers course completion card issued by a training center of the American Heart Association or a course completion card for adult, infant and child CPR issued by the American Red Cross.(Recommended)
4. Is available to the pupil where anaphylaxis is likely to occur
5. Has been trained in tasks specific to the above-named student

Neither the capability of self-administration, the presence of antihistamine in the doctor's order, nor a co-morbidity of asthma should preclude a delegation of epinephrine administration for a student for anaphylaxis. Epinephrine and a trained adult user must be immediately available and accessible to the child who needs it.

If the procedures specified in P.L 2007, c. 57 are followed, the district shall have no liability as the result of any injury arising from the administration of epinephrine to the pupil and we, the parents or guardians, indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine to the pupil.

Permission is effective for the school year in which it is granted and is renewed for each subsequent year in accordance with P.L 2007, c. 57.

Designee's Signature

Designee's Signature

Designee's Signature

Designee's Signature

Parent/Guardian's Signature

Nurse's Signature

Building Principal's Signature

Date