Clifton Public Schools
Nursing Services

MEDICATION FORM FOR ALLERGIC REACTION-complete both pages

This form must be completed by a PHYSICIAN/ADVANCED PRACTICE NURSE **AND** PARENT **EACH SCHOOL YEAR** for any student requiring Epinephrine while in school or at a school-sponsored event.

Student's Name:_______________________________ DOB: _______________ Grade: ______School___________ ID #___________

ALLERGY TO: ____

Asthma Yes* ( ) No ( ) *Higher risk for severe reaction

SECTION 1-TREATMENT – To be completed by the physician/advanced practice nurse:

Symptoms (The severity of symptoms can quickly change!) **Give checked medication**

Symptoms		Give checked medication	
If food allergen has been ingested or student has been stung by an insect (if order is for insect sting allergy), but no symptoms		( )Epinephrine	( )Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	( )Epinephrine	( )Antihistamine
Skin	Hives, itchy rash, swelling on face or extremities	( )Epinephrine	( )Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	( )Epinephrine	( )Antihistamine
General	Panic, sudden fatigue, chills, fear of impending doom	( )Epinephrine	( )Antihistamine
Throat †	Tightening of throat, hoarseness, hacking cough	( )Epinephrine	( )Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	( )Epinephrine	( )Antihistamine
Heart †	Thready pulse, passing out, fainting, pale, blueness	( )Epinephrine	( )Antihistamine
If reaction is progressing (several of the above areas affected)		( )Epinephrine	( )Antihistamine

† Potentially Life Threatening

Please indicate dose and type of epinephrine auto inject.

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM Epipen _____Auvi-Q______Generic________

Antihistamine Brand or Generic: ________________________________

Antihistamine Dose:____

CALL 911-state "a student had a severe allergic reaction, and additional epinephrine may be needed! Please send paramedics". Student MUST be transported to the nearest hospital. Then call parents. TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT (Please check one answer):

P.L.2007, c 57 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine to a student who has anaphylaxis when a nurse is not physically present at the scene.

____ **Delegate Order- For suspected exposure to allergen(s) listed above,** delegates are to immediately administer prescribed auto-inject epinephrine. Note: ▪ *Delegates will not be able to administer an antihistamine as the first treatment*.

____**This student's order should not be delegated.**

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Please check all that apply):

P.L. 2007, c 57 directs that a student may be permitted to self-administer medications for potentially life-threatening illness provided proper procedures are followed.

_____ This student has a potentially life-threatening allergy and will carry epinephrine at all times in school or when attending a school sponsored event.

_____ This student understands, has been instructed, and is capable of the proper technique of self administration of the prescribed medications(s).

_____ This student is aware that he/she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to an adult immediately.

Physician's Signature: ______________________________ Date: ______________ Physician's Stamp

Approved by school physician ___________________________________ date_______________

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Parent complete other side

ALLERGIC REACTION/MEDICATION FORM

SECTION II – To be completed by parent/guardian:

My child, ___________________________________, a student in the Clifton Public School System, has a potentially life-threatening allergy that could result in anaphylaxis. This student requires emergency administration of epinephrine via a pre-filled, auto-injector mechanism containing epinephrine in the event of anaphylaxis.

My child has my permission, in accordance with P.L. 2007, c 57, to carry and self administer the prescribed medication.

( ) Yes ( ) No

In order to keep my child safe at school or at a school sponsored event, I consent to the following for the **20__/20__ school year**.

- ✓ Medication(s) will be sent to school to be kept in the Health Office.
- ✓ I will assure that the medication is in its original prescription container.
- ✓ I will note the expiration date of the medication and promptly replace any expired medication.
- ✓ When applicable to MD order, I will remind my child to have the medication with them at all times. If an antihistamine is prescribed to be given along with epinephrine for anaphylaxis, a single, pre-measured dose of antihistamine (in the original, labeled container) is to be kept with the student along with the epinephrine.
- ✓ 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 in relation to this medical issue.
- ✓ I give permission for the school nurse to share this medical information with members of the CPS staff who have direct responsibility for my child in school or at a school sponsored event.
- ✓ I give permission for any CPS employee or agent (who is a trained delegate pursuant to P.L. 2007, c 57) to administer epinephrine to my child in the absence of the School Nurse (school delegate list changes each year, and will be available upon request from your Certified School Nurse).
- ✓ I understand that the CPS 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. We, the parents or guardians, indemnify and hold harmless the CPS district and its employees or agents against any claims arising out of the administration or self-administration of medication by the pupil. 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's Name Parent/Guardian's Name

_____________________________________ _____________________________________
Parent/Guardian's Signature/date Parent/Guardian's Signature/date

Emergency Contacts – Name/Relationship/Phone Numbers

1.________________________________ (H) ________________ (C) __________________ (W)___________________

2.________________________________ (H) ________________ (C)__________________ (W)____________________

3.________________________________ (H) ________________ (C)__________________ (W)____________________

Approved by school physician ____ date________________

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