TWO-SIDED FORM

TEANECK SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's Name _____ Birth Date _____ Grade/Teacher _____

The above student is allergic to: _____

☐ Ingestion ☐ Contact ☐ Inhalation

Previous episode of anaphylaxis ☐ Yes ☐ No
Asthmatic ☐ Yes ☐ No

MEDICATIONS

ANTIHISTAMINE: Medication _____ Dose _____

Give antihistamine for the following checked symptoms:
☐ Contact with allergen, with or without symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Other _____

EPINEPHRINE: Medication _____ Dose _____

Give epinephrine for the following checked symptoms:
☐ Contact with allergen, with or without 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 _____

AFTER GIVING EPINEPHRINE, 911 AND THE PARENT/GUARDIAN WILL BE CALLED.

OTHER INSTRUCTIONS _____

Note: NJ State Law (P.L.2007, CHAPTER 57) requires every student with an EpiPen order to have a delegate assigned to him/her unless the HCP and/or parent/guardian feel(s) that it is not indicated. Please indicate your preference:

☐ Delegate required ☐ Delegate NOT required

PLEASE NOTE: DELEGATES ARE NOT PERMITTED TO ADMINISTER AN ANTIHISTAMINE.

If the nurse is not available, do you want the antihistamine order to be omitted and have the delegate administer epinephrine as indicated above? ☐ YES ☐ NO

This student has been trained and is authorized to self-administer and carry the following medication(s).
☐ epinephrine – single dose unit ☐ antihistamine – single dose unit

☐ This student is not authorized to self-administer the medication(s) named above.

Physician's Signature _____ Phone # _____

Date _____

Physician's Stamp _____

OVER

Parents/Guardian

This permission is for emergency treatment for one school year only. Should permission be necessary in the future, a new form will need to be submitted.

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine 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 Teaneck 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 Teaneck School District policy are followed, I shall indemnify and hold harmless the Teaneck School District and its employees or agents against any claims arising out of self administration of medication by my child.

_____ _____

Signature of Parent/Guardian Date

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 Teaneck 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 Teaneck School District Policy are followed, I shall indemnify and hold harmless the Teaneck 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

Please Sign

I understand that under N J Law, a trained delegate will be assigned to administer epinephrine 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.

_____ _____

Signature of Parent/Guardian Date

_____

Signature of School Nurse Date

TEANECK PUBLIC SCHOOL

MEDICAL DEPARTMENT

Authorization for Release of Medical Information

Student_____ Date_____

DOB_____ School_____

As parent/guardian of the above named student, I hereby authorize the release of pertinent information (medical conditions, allergies, and/or medical regimes, etc.) to the school nurse. This consent is valid for the _____school year.

_____ _____

Date Signature of Parent/Guardian