

**CALIFON SCHOOL
ALLERGY ACTION PLAN**

SCHOOL YEAR _____

Student's Name _____

Date of Birth _____

Weight _____

Picture _____

MEDICAL PRACTITIONER PLEASE NOTE: Do not leave any blank spaces. This form will be returned to you and may cause a delay in the administration of your patient's medication or treatment.

ALLERGY TO: _____

Does this student have asthma? Yes* No *Higher risk for severe reaction

This student may carry their medication with them at all times so that it is available when and where it is needed. Yes No

Treatment by Nurse When Present

Symptoms:	Give checked medication:
If a food allergen has been ingested, or student was stung by a bee but no symptoms	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Mouth Itching, tingling, or swelling of lips, tongue or mouth	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Throat Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Lungs Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Heart Weak or thready pulse, low blood pressure, fainting, pale, cyanosis	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ Other list _____	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
■ If reaction is progressing (several of the above affected), give _____	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine

Potentially life threatening. The severity of symptoms can quickly change.

Choose only one administration order:

Give Antihistamine & Epinephrine at same time

Give Antihistamine first, observe for further symptoms and give Epinephrine PRN

Dosage:

Epinephrine: inject intramuscularly (circle one)

Epi-Pen®

Epi-Pen Jr.®

Antihistamine: give _____

Medication/dose/route

Other: give _____

Medication/dose/route

9-1-1 will be activated when: _____

Treatment by Delegate (When Nurse Not Present)

NJ State Law requires that the school nurse designate additional employees of the school district who volunteer to administer epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene.

Delegate Order:

For **suspected** allergen exposure, delegates are to immediately administer epinephrine (circle one):

Epi-Pen®

Epi-Pen Jr.®

9-1-1 WILL BE ACTIVATED AND THIS STUDENT WILL BE TRANSPORTED IMMEDIATELY AFTER SUSPECTED ALLERGEN EXPOSURE TO THE HOSPITAL EMERGENCY ROOM BY AMBULANCE.

Treatment by Student (Self-Administration)

NJ State Law allows for the self-administration of medication by a student with a potentially life-threatening illness or a life threatening allergic reaction provided proper procedures are followed.

This student may self-administer the prescribed medication(s) (epinephrine and antihistamine). Yes No

(If yes, complete the questions below. To have permission to self-administer, all questions listed below must be checked "yes".)

I certify that this student is capable of and has been instructed in the proper administration of this necessary medication. Yes No

This student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used the above-prescribed medication(s). Yes No

--over--

Self-Administration Dosage:

Epinephrine: student should inject immediately (circle one)

Epi-Pen®

Epi-Pen Jr.®

Antihistamine: student should take immediately _____

Medication/dose/route

Under NJ state law, orders for **antihistamine alone** cannot be self-administered.

9-1-1 WILL BE ACTIVATED AND THIS STUDENT WILL BE TRANSPORTED IMMEDIATELY AFTER SUSPECTED ALLERGEN EXPOSURE TO THE HOSPITAL EMERGENCY ROOM BY AMBULANCE.

◆ Medical Practitioner's Stamp _____

◆ Medical Practitioner's Signature (MD, DO or Advanced Practice Nurse) _____

Date _____

TO BE COMPLETED BY THE PARENT

I agree with my medical practitioner's instructions and give permission to the school nurse to share necessary information concerning my child's allergy with school personnel on a need- to- know basis only. Yes No

By also signing this acknowledgement I, the parent/guardian, authorize the school nurse to assist my child in taking the above named medication(s). I agree that I will not hold liable the school district or school nurse who is directed by me to assist my child in taking the above named medication(s).

◆ Parent/Guardian Signature _____

Date _____

PARENT ACKNOWLEDGEMENT AND AUTHORIZATION IF STUDENT IS SELF ADMINISTERING

I/we the parents/guardians, of the above named student certify that he/she is capable of and has been instructed in the proper administration of the above named medication and authorize the above named student to self-administer the medication as identified above.

By also signing this acknowledgement, I/we understand that the Lebanon Township Board of Education, its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by this pupil, and that we hereby indemnify and hold harmless the Board, its employees or agents against any claims arising out of the self-administration of said medication by this pupil.

◆ Parent/Guardian Signature _____

Date _____

STUDENT ACKNOWLEDGEMENT AND AUTHORIZATION IF SELF ADMINISTERING

I, the above named student, acknowledge that I am capable of and have been instructed in the proper administration of the above named medication(s). I am also aware that I must immediately report to the school nurse or teacher if I suspect an allergen exposure, any signs of allergic reaction, or have used the above-prescribed medication(s).

◆ Student's Signature _____

Date _____