

***Roselle Park Board of Education
Roselle Park, NJ 07204***

***Epinephrine Auto Injector Procedure
for
Bee/Wasp/Stinging Insect Allergies or Food allergies***

Dear Parent/Guardian of _____,

You have informed us that your child, _____, has a severe allergy to _____ . Since he/she may require the administration of epinephrine via an auto injector in the event of an anaphylactic reaction it is necessary to cooperatively develop a plan of action.

If able and age appropriate, the physician may choose to prescribe epinephrine to be self-administered by your child in the event of an anaphylactic reaction. Under specific circumstances, in the event that the student can not self-administer and if a certified school nurse is not available for the administration of the epinephrine auto injector, non-medical school personnel may be trained to administer the medication. **Only epinephrine** may be administered by the trained designee – other medications such as Benadryl may only be administered by the school nurse or self-administered by the student. #911 will be called immediately in the event of an emergency whether or not trained personnel are available.

It is your responsibility to inform the school of all after school and before school activities, sponsored by the Board of Education, in which your child participates in order for a trained designee to be present at the activity. You must update this information throughout the school year as activities change.

The attached forms must be completed by you, your child, if self-administering the medication, and the physician. A conference involving you, your child and pertinent school personnel may be organized once the attached forms are completed.

All efforts will be made to provide a safe and healthy environment for your child. Please do not hesitate to contact me with any questions, concerns or suggestions.

Yours truly,

Jan Haddad, RN
Roselle Park High School
School Nurse
(908) 241-4550, ext. 2071

Brenda Litterer, RN
Roselle Park Middle School
School Nurse
(908) 245-1634, ext. 3109

Roselle Park Public Schools
Roselle Park, NJ 07204
"Committed to Excellence"

**RECOMMENDATION OF PRIVATE PHYSICIAN FOR STUDENT
SELF ADMINISTRATION OF
EPINEPHRINE AUTO INJECTOR OR
EPINEPHRINE AUTO INJECTOR WITH BENADRYL (Single unit dose)**

TO BE COMPLETED BY THE PHYSICIAN:

In order to protect the health of _____ Class _____
(Student's name)

it may be necessary for him/her to use an Epinephrine Auto Injector in the case of anaphylactic shock.

Allergen: _____

Previous Symptoms: _____

- | | |
|--|---|
| <input type="checkbox"/> Epinephrine Jr. (0.15mg) IM | <input type="checkbox"/> Epinephrine Sr. (0.30 mg) IM |
| <input type="checkbox"/> Auvi-Q (0.15mg) | <input type="checkbox"/> Auvi-Q (0.30mg) |

Side Effects: _____

- Benadryl Dosage _____ PO. Side Effects: _____

The above named student has received instructions in the use of the Epinephrine Auto Injector with or without Benadryl and has demonstrated confidence and competence in self-administration. Failure to receive immediate medical treatment will result in a medical emergency. I, therefore, recommend that he/she be allowed to carry and self-medicate with the Epinephrine Auto Injector with or without Benadryl as described above.

Physician's Name (please print)

Physician's Signature

Date

TO BE COMPLETED BY THE PARENT:

I give permission for my child to self-medicate as described above. I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants, and representatives which may result from administration of the medication. I will be fully responsible for keeping track of the expiration date of the medication and replacing it when it has expired.

MY CHILD ATTENDS THE ROSELLE PARK BOARD OF EDUCATION EXTENDED DAY PROGRAM ___ YES ___ NO

(Parent/Guardian Signatures)

Date

School

(Parent/Guardian Signatures)

Date

School

MEDICATION CONTRACT

Date: _____ Name of Medication: _____

1. I understand that I will use this medication as directed by my physician.
2. I will carry the medication with me at all times, including outside during gym classes, on field trips, and at all athletic events. The medication will be easily accessible. I will be responsible in using it. I understand that if I do not have my medication with me during practices, games, events, etc. I will be excluded from participating in the activity.
3. I have been instructed how to self-administer this medication and understand the side effects and effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else.
4. I will notify teacher/supervisor/coach immediately upon use of the medication. 9-1-1 will be called. The School Nurse will be notified as soon as possible.
5. I understand that if I do not abide by the regulation, I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of the school year.

Student's Signature _____ Date _____

Parent's Signature _____ Date _____

Roselle Park Board of Education
EMERGENCY HEALTH CARE PLAN

STUDENT'S NAME _____
D.O.B. _____ **GRADE** _____ **SCHOOL YEAR** _____

ALLERGY TO: _____

STUDENT HAS HAD AN ANAPHYLACTIC REACTION IN THE PAST: (YES) (NO)
Date of last anaphylactic episode: _____

SIGNS OF AN ALLERGIC REACTION

Please indicate the patient's prior reactions:

- | | |
|---------------|--|
| _____ MOUTH | Itching and swelling of the lips, tongue, or mouth. |
| _____ THROAT | Itching and/or a sense of tightness in the throat, hoarseness and hacking cough. |
| _____ SKIN | Hives, itchy rash, and/or swelling about the face or extremities. |
| _____ ABDOMEN | Nausea, abdominal cramps, vomiting, and/or diarrhea. |
| _____ LUNG | Shortness of breath, repetitive coughing, and/or wheezing. |
| _____ HEART | "Thready" pulse, "passing out." |

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL THE ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

ACTION: Please circle action to be taken in the event of ingestion of allergen or insect sting/bite:

1. Epi-pen Jr. ----- Epi-pen Sr.
2. Call the rescue squad -----911.
3. Call: MOTHER home _____ FATHER home _____
work _____ work _____
4. Call: PHYSICIAN Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

Parent Signature

Date

M.D./D.O. _____

Medical Provider Signature

Date

5/16JH

Roselle Park Board of Education
Roselle Park, NJ 07204

DESIGNEE CONSENT FORM

STUDENT'S NAME: _____ D.O.B. _____ CLASS _____

DESIGNEE NAME: _____ POSITION _____
DESIGNEE NAME: _____ POSITION _____
DESIGNEE NAME: _____ POSITION _____
DESIGNEE NAME: _____ POSITION _____

TO BE COMPLETED BY DESIGNEE:

I/we consent to be designee(s) to administer the Epinephrine Auto Injector/Auvi-Q to the above named student in an emergency, in the absence of the school nurse. I/we agree to attend and complete training sessions by the school nurse. This consent is for the above named student only and is effective for this school year only.

_____	_____
Designee's Signature	Date
_____	_____
Designee's Signature	Date
_____	_____
Designee's Signature	Date
_____	_____
Designee's Signature	Date

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby give my consent to permit _____ as the designated person in an emergency to administer the Epinephrine Auto Injector/Auvi-Q to my child, _____, in the absence of the school nurse. I further agree to indemnify and hold harmless the Roselle Park Board of Education and its school employees from any claims arising from administration of the Epinephrine Auto Injector to my child.

I have been informed and understand that the Roselle Park Board of Education has no liability as a result of any injury arising from the proper administration of the Epinephrine Auto Injector used for the emergency administration of the epinephrine to my child for anaphylaxis.

The permission for the emergency administration of epinephrine via auto injector to students for anaphylaxis is effective for the school year it is granted and must be renewed for each subsequent school year.

I do not want non-medical personnel trained to administer the Epinephrine Auto Injector/Auvi-Q to my child, _____, in an emergency situation. Only the school nurse may administer the medication in an emergency. If the nurse is not available #911 will be called.

_____	_____
Parent/Guardian's Signature	Date

After School Activities and Epinephrine Auto-Injector

Written orders have been received from your private physician stating that your child requires the administration of epinephrine for anaphylaxis. During the school day, the epinephrine may be self-administered, given by the school nurse or by a designee. After school, when the school nurse is not present, a trained epi-pen delegate should be available to administer the epinephrine.

According to Roselle Park Board of Education policy, it is the parent/guardians' responsibility to notify the school nurse and/or building principal in writing if their child attends any after school activities or programs sponsored by the Roselle Park Board of Education.

STUDENT NAME _____

LIST of ALL AFTER SCHOOL ACTIVITIES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Parent/guardian signature _____

Date _____