Howell Township Public Schools

PROUD OF OUR SCHOOLS • CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

The New Jersey Department of Education has implemented NJ Public Law 2007, Chapter 57. This law includes specific language pertaining to the administration of epinephrine to students. Any student whose physician orders epinephrine for anaphylaxis shall be offered a volunteer, non-medical designee to administer epinephrine via a pre-filled auto-injector mechanism when the school nurse is unavailable. This also pertains to those students who are capable of and have self-medication orders.

Please review the enclosed forms and discuss them with your child's physician. All completed forms should be returned to your child's school nurse.

Pre-filled auto-injector mechanism(s) are to be supplied to the school nurse in a properly labeled container, with the child's name, dosage, etc., on the pharmacist's label. you are requesting a designee, a minimum of two injectors are required. Also, please notify the school nurse in writing of any school sponsored activities in which your child will be participating so that plans can be made for his/her safety.

If you have any questions, please contact your child's school nurse.

Sincerely,

Dorothea Fernandez

Dorothea Fernandez
Director of Pupil Services

DF:ak

Enclosures: Parent Request/Refusal for Pre-filled Auto-Injector Mechanism Administration When Nurse is Unavailable/Hold Harmless
Medication Order Sheets (2)
Self-Medication Order Sheet (2)
Food Allergy & Anaphylaxis Emergency Care Plan
Bus Transport Emergency Medical Plan
Individualized Emergency HealthCare Plan

(2/2017)

Howell Township Public Schools

PROUD OF OUR SCHOOLS • CONCERNED FOR OUR CHILDREN

Parent Request for Pre-filled Auto-Injector Mechanism (EpiPen) Administration When Nurse is Unavailable

Student's Name______________________________ School______________________

I give permission for a trained, delegated, nonmedical person (delegate) to administer epinephrine via pre-filled auto-injector mechanism to my child when needed and a nurse is not present. My child is allergic to______________________. I understand that when epinephrine is administered to my child, 911 will be called and EMS will transport my child to the hospital.

I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising out of, or connected with, the administration of medication by a delegate.

______________________________ ______________________

Parent/Guardian Signature Date

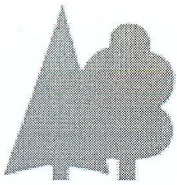
Parent Refusal for Pre-filled Auto-Injector Mechanism (EpiPen) Administration When Nurse is Unavailable

I waive my right to have a delegate administer prescribed epinephrine via pre-filled auto-injector mechanism to my child in the event of an exposure to a known life threatening allergen when a nurse is not present. I understand that 911 will be called immediately.

______________________________ ______________________

Parent/Guardian Signature Date

(2/2017)



Howell Township Public Schools

PROUD OF OUR SCHOOLS ▪ CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

Should it be necessary for your child to receive medication during school hours, you must present **this form** or an order from your personal physician, stating medication, **dosage**, **time of administration,** and the length of time your child will be on medication. This includes Tylenol, Motrin, cough drops and **all** over-the-counter medications. Any changes in these directions must be verified by a call to the school nurse, as well as a written note from the physician.

Any dangerous condition being experienced by a child on medication should be spelled out in detail with procedures to follow should a reaction occur. **Medicine must be properly labeled and in the original container, with the child's name, dosage, etc., on the pharmacist's label. The parent/guardian must transport all medication to and from school, unless a child has a doctor's signed permission to self-medicate and therefore carry an emergency medication (inhaler, pre-filled auto-injector mechanism).**

Sincerely,

Dorothea Fernandez

Dorothea Fernandez
Director of Pupil Services

Request for Administration of Medication

Student______________________________Homeroom_____________________Date _________

Diagnosis______________________________________

Name of Medication____________________Dosage ________Time of Administration __________

Daily or PRN: _________________to be given_________ minutes before physical education or recess

To begin on ____________________ and conclude on ____________________________________

Possible side effects to be observed: ____

Special Instructions ____

Is this medication needed during field trips? Yes ________ No __________

Is this medication to be given on early dismissal day? Yes _________ No ____________________

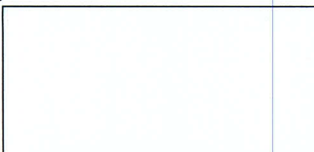
Is child on any other medication? ____

Physician's Signature _____________________ Parent/Guardian Signature_____________________

School Physician's Approval ______________________ ________________________

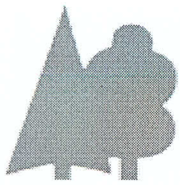
Signature of Principal/Approval

PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.



Physician's Stamp

(2/2017)



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Dorothea Fernandez

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Student ________________________ Homeroom ____________________ Date __________

Diagnosis ______________________________

Name of Medication ____________________ Dosage _________ Time of Administration ___________

Daily or PRN: _________________ to be given _________ minutes before physical education or recess

To begin on ____________________ and conclude on ____________________________________

Possible side effects to be observed: ____

Special Instructions ____

Is this medication needed during field trips? Yes _________ No ___________

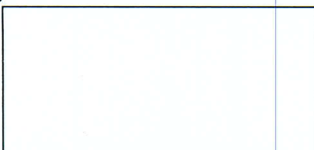
Is this medication to be given on early dismissal day? Yes __________ No ____________________

Is child on any other medication? ____

Physician's Signature ____________________ Parent/Guardian Signature ____________________

School Physician's Approval ______________________ ________________________
Signature of Principal/Approval

PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.



Physician's Stamp

(2/2017)

Howell Township Public Schools

Permission to Self-Administer Emergency Medications

Howell Township Board of Education Policy 508 allows for the self-administration of medication for potentially life-threatening conditions only. A life-threatening condition is a condition that requires an immediate response to specific symptoms that if left untreated may lead to potential loss of life, for example: adrenaline for anaphylaxis, inhalers for asthma. This medication order will remain in effect for the current school year. Please note it is the parent's responsibility to ensure that the medication carried by the child has not reached its expiration date.

*******************<u>**Part I – To be completed by physician**</u>******************

The student named below has a potentially life-threatening condition. This student has been instructed in the proper method of self-medication for this condition and is capable and responsible to self-administer.

Student: ______________________________ Date: ________________

Potentially Life-Threatening Diagnosis: ______________________________

Medication: ____________________ Dosage: ____________________

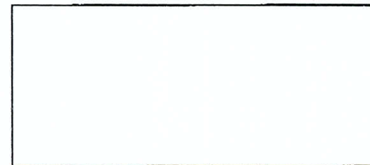
Additional Instructions: ______________________________

Side Effects: ______________________________

Physician's Name (please print):__________________Telephone:__________

Physician's Signature: ____________________

Date: ____________



Physician's Stamp

*************<u>**Part II – To be completed by parent/legal guardian**</u>*************

I, as parent/guardian of______________________________, request the Howell Township Board of Education to permit my child to carry and self-administer the emergency medication as prescribed above by their physician. My child understands the proper use of this medication and will be responsible for it. I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising from the self-administration of medication.

Parent/Guardian Signature ______________________Date:____________

School Physician____________________ Principal__________________

Howell Township Public Schools

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Howell Township Board of Education Policy 508 allows for the self-administration of medication for potentially life-threatening conditions only. A life-threatening condition is a condition that requires an immediate response to specific symptoms that if left untreated may lead to potential loss of life, for example: adrenaline for anaphylaxis, inhalers for asthma. This medication order will remain in effect for the current school year. Please note it is the parent's responsibility to ensure that the medication carried by the child has not reached its expiration date.

*********************Part I – To be completed by physician*******************

The student named below has a potentially life-threatening condition. This student has been instructed in the proper method of self-medication for this condition and is capable and responsible to self-administer.

Student: ______________________________ Date: ________________

Potentially Life-Threatening Diagnosis: ______________________________

Medication: ____________________ Dosage: ____________________

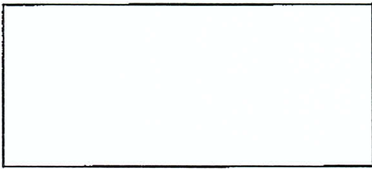
Additional Instructions: ______________________________________

Side Effects: ____

Physician's Name (please print):__________________Telephone:__________

Physician's Signature: ____________________

Date: ____________



Physician's Stamp

**************Part II – To be completed by parent/legal guardian**************

I, as parent/guardian of______________________________, request the Howell Township Board of Education to permit my child to carry and self-administer the emergency medication as prescribed above by their physician. My child understands the proper use of this medication and will be responsible for it. I hereby agree to indemnify and hold harmless the Howell Township Board of Education and its employees/agents from any and all losses, claims, injuries, damages or expenses arising from the self-administration of medication.

Parent/Guardian Signature ______________________Date:____________

School Physician______________________ Principal__________________

(2/2017)

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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 allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

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 emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient 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 or Generic: ______________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________

Antihistamine Dose: ______________

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

____

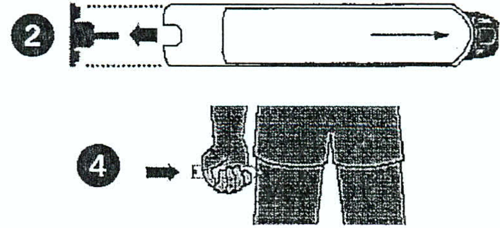
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

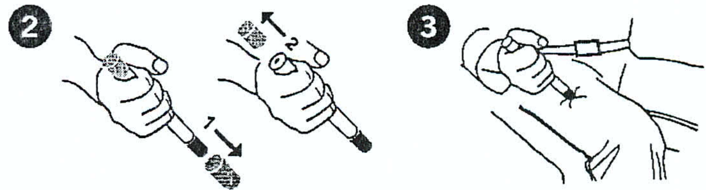
Food Allergy Research & Education

EPIPEN® AUTO-INJECTOR DIRECTIONS



1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.

ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR 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 enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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 worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: __________

PARENT/GUARDIAN: ______________________ PHONE: __________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

Howell Township Public Schools

PROUD OF OUR SCHOOLS • CONCERNED FOR OUR CHILDREN

BUS TRANSPORT EMERGENCY MEDICAL PLAN

*NAME:*____

*ADDRESS:*______________________________________

*ROUTE #:*______________________________________

1. ____________________ has a history of severe allergy to____________________

   ____.

2. It can be so severe that ***"anaphylaxis"*** can occur.

   Anaphylaxis is a rapid, severe allergic response that occurs when a person is exposed to an allergy-causing substance. It is brought on when the allergen enters the bloodstream, causing the release of chemicals throughout the body that try to protect it from the foreign substance.

3. Signs and symptoms of ***"anaphylaxis"*** include hives or rash, swelling of face and/or extremities, tingling of lips and mouth, a feeling of fullness in the throat, flushing of face or body, coughing, wheezing, shortness of breath, nausea, vomiting, abdominal cramps, diarrhea, increased heart rate, low blood pressure, fainting. Coma, respiratory and cardiac arrest can also occur.

4. If ____________________ shows any of the symptoms of anaphylaxis noted above:

   A. Radio for help. Ask for 911 emergency response to meet you at your location. Tell the dispatcher: "I am transporting a __________ year old child with a history of severe __________ allergy resulting in anaphylaxis. His/her symptoms are.......
   B. Stay with the child, speak calmly, reassure him/her that people are coming to help.
   C. When ____________________ is to be transported to the hospital, send this form with emergency telephone numbers with him/her.
   D. Make sure that your bus company contacts the parents and the school to explain the reaction and to which hospital the child has been transported.
   E. Fill out the attached accident/incident report, make a copy for your files, and drop the completed form off at school.
   F. If you have any questions, please contact the school nurse at ________________. Also, please keep in close communication with me throughout the year with any changes that may occur with the bus run as the year progresses.

5. The student will be seated at the front of the bus to the right of the bus driver. ______ ______

   Accept *Decline*

____________________ __________ ____________________ ________

Certified School Nurse *Date* *Bus Driver* *Date*

____________________ __________

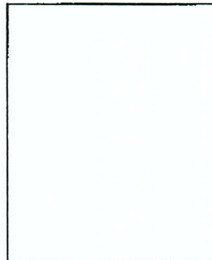
Parent/Guardian Signature *Date*

EMERGENCY CONTACTS

*1. Name:*____________________ *Relationship:*__________ *Phone No:*__________

*2. Name:*____________________ *Relationship:*__________ *Phone No:*__________

HOWELL TOWNSHIP SCHOOL DISTRICT
INDIVIDUALIZED EMERGENCY HEALTHCARE PLAN for STUDENTS WITH SEVERE ALLERGIES



Student:______________________ Teacher:__________ Date:__________

Severe allergy to:____

Birthdate: _______ Physician: ________________ Phone#: __________

Preferred hospital in case of emergency: _______________________

Epinephrine delegate(s): Yes____ No:____

Name of delegate(s):______________________________________

Location of Epinephrine: **Main Office/ Health Office/ Student Carries**

CONTACT INFORMATION

Parent /Guardian: 1.______________________ 2. ______________________	**Home Phone:** ______________ **Work:** ______________ **Cell:** ______________ **Work:** ______________ **Cell:** ______________
Emergency Contact:	**Home Phone:** ______________ **Work:** ______________ **Cell:** ______________

Previous Reaction: ____

STUDENT -SPECIFIC EMERGENCIES

If you see any of these signs or symptoms of an allergic reaction	*Do This*
Mouth- Itching & swelling of lips, tongue, or mouth	**1. If student presents with any of these signs or symptoms, notify nurse immediately@_________ and Main Office @__________. If nurse is unavailable, call 911 immediately and contact delegate if indicated above.***
Throat- Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough, choking	**2.Student has order for_____mg Benadryl:Yes___No___** **Student carries Benadryl: Yes______No______** **Benadryl kept in Health Office: Yes___No______** **Student may self administer epinephrine:** **Yes_______No_______** **Epinephrine ____mg to be administered** **Dose may be repeated: Yes______ No______**
Skin- Hives, itchy rash, and/or swelling about the face or extremities, flushed face	**3. Note and Record:** **Time of Incident: ________** **Time of Administration of Epinephrine and site:** **____________** **Circumstances (where and what was the allergen):** **________________________________.** **Contact parent. Remain with student.**
Gut- Nausea, abdominal cramps, vomiting, and/or diarrhea	**4. Student must be transported to hospital if epinephrine is administered.**
Lung- Shortness of breath, repetitive coughing, and/or wheezing	
Heart- "Thready" pulse, "passing-out", rapid heart rate	***For After School Activities** **Activate EMS 911. Notify administrator or site supervisor who will contact delegate if in building.**
Other- Dizziness, unsteadiness, sudden fatigue, chills, loss of Consciousness	***Parent to notify nurse if student is staying after school.**

If an emergency occurs:

1. If the emergency is life-threatening, immediately call 9-1-1 and request Advanced Life Support. .
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or the school nurse.
   State who you are, where you are and the problem.

School Nurse: ____________________ Phone: ________________

Parent Signature: __________________ Date: ________________

Copy to: _______________________ _______________________

(2/2017)