

**ROBBINSVILLE SCHOOL DISTRICT
HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT**

Student's name _____ Grade/Teacher/HmRm _____

The above student is allergic to: _____

Asthmatic Yes No

MEDICATIONS

PLEASE NOTE: The School Nurse by law may administer any medication with physician's orders and parental consent, but trained non-medical designees, who may give emergency treatment in the School Nurse's absence, are NOT permitted by law to administer any medications other than epinephrine via auto-injector mechanism.

EPINEPHRINE: EpiPen EpiPen Jr. Other _____

School Nurse or designee: Give epinephrine for the following checked symptoms:

- Contact with allergen, but no 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, call 911, parent, and healthcare provider.

ANTIHISTAMINE: Medication _____ Dose _____

School Nurse only: Give antihistamine for the following checked symptoms:

- Contact with allergen, but no 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 _____

OTHER INSTRUCTIONS _____

- This student has been trained and is authorized to **self-administer** the following medication(s) named above. epinephrine – single dose unit antihistamine – single dose _____ mg
- This student is not authorized to self-administer the medication(s) named above.

Healthcare Provider's signature _____ **Date** _____

Healthcare Provider's Stamp _____

Parents signature _____ **Date** _____

Parent Refusal

This is to inform you that the NJ state laws now require all schools to (attempt to) obtain an injectable epinephrine delegate for all students who currently have injectable epinephrine orders. This now applies during school hours as well as all after school sponsored activities. In case a school nurse is not available, a delegate will be able to administer one dose injectable epinephrine in times of emergency during school hours. These delegates will receive training from the School nurse. The delegate(s) who is/are assigned to your child will be informed of your child's specific allergies, symptoms & pertinent medical history only. No other medical information will be given to them. These delegates are **not allowed** to give 1st line antihistamine (i.e. Benadryl) treatment. They are only allowed to administer one dose of the injectable epinephrine.

If you do not wish for your child to have an injectable epinephrine delegate, please sign the form below and return it to the Health Office.

I do not give permissions for an injectable epinephrine delegate(s) to be assigned to

(students name)

parents/guardian signature

Date

Emergency Information

Physician

Phone Number

Parent

Phone Number(s)

Emergency Contacts:

Name/Relationship

Phone Number(s)

1) _____

2) _____

Health Office Use Only:

Epinephrine Delegates:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____