REQUIRED DOCUMENTATION FOR A STUDENT WITH AN EPI-PEN

1. Physician must fill out and sign forms Epi-1 and Epi-3.
2. Parents must fill out and sign Epi-2 and Epi-3
3. If self-administering medication, parent AND physician must sign self-administration form.
4. School Nurse reviews all paperwork, completes emergency plan and signs delegate training form when training is completed.

PHYSICIAN'S PERMISSION

for Delegating Administration of Epi-Pen When School Nurse Is Not Present

Student's Name:_____ DOB_____

Anaphylactic allergy to:

- ☐ Insect stings such as bees or wasps _____
- ☐ Exposure to the following allergen _____
- ☐ Food allergy to _____

This student may experience a life threatening reaction to the allergens listed above, and does not have the ability to self-administer an injection of epinephrine. I understand that when the school nurse is not available, a trained delegate will administer the Epi-pen or Epi-pen Jr. I also understand that if the school nurse or the trained delegate is not available, 911 will be called.

If there is reasonable suspicion that the above named child has been stung or has ingested the above named allergen, or if any of the following signs of anaphylaxis develop, I give my permission for the trained delegate to follow this protocol. Signs of an anaphylactic reaction include: itching or swelling of the lips, tongue, or mouth; itching or tightness in the throat, hoarseness; hives, itchy rash, and swelling of the face or extremities; nausea, abdominal cramps, vomiting, diarrhea; shortness of breath, wheezing or hacking cough; thready pulse or passing out.

1. Administer immediately: ___ Epi-pen (.3mg)
   ___ Epi-pen Jr. (.15mg)
2. Call 911 and parent immediately.
3. Begin CPR if pulse or breathing is absent.
4. Make child as comfortable as possible until the ambulance arrives.

_____ _____

Physician's Signature **Date**

Office stamp:

Epi-1

*Please note that the NJ. State Law PL 1997, C.368 allows the delegate to administer no medications except the Epi-pen or Epi-pen Jr.

SCHOOL NURSE PROGRAM

Camden County Non-Public Schools

PARENT PERMISSION FORM for DELEGATING EPI-PEN ADMINISTRATION

Student Name _____ D.O.B._____

I give permission for the school nurse or her trained delegate to administer an Epi-pen or an Epi-pen jr. to my child _____, for the treatment of anaphylaxis as identified by my child's doctor. I understand that if the school nurse is not available, a trained delegate will administer the Epi-pen. I also realize that if for some reason, neither the school nurse nor the trained delegate is available, 911 will be called.

I acknowledge that if the established protocols are followed, the Camden County Health Department, _____School and its employees shall have no liability as a result of any injury arising from the administration of the Epi-pen to my child. I indemnify and hold harmless the school and its employees or agents against any claim arising out of the administration of the Epi-pen to my child.

I also understand that this permission is effective for this school year only, and must be renewed for each subsequent school year.

Name of Delegate: _____

Parent's Signature: _____Date: _____

Epi-2

EMERGENCY HEALTH CARE PLAN - EPI 3

Student's Name_____ DOB _____ Teacher_____

Allergy to _____

Trained Delegate_____

School Nurse_____

SIGNS OF ALLERGIC REACTION INCLUDE:

Systems	Symptoms
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
Gastrointestinal	nausea, abdominal cramps, vomiting, diarrhea
Respiratory*	shortness of breath, repetitive coughing, and/or wheezing
Cardiovascular*	'thready' pulse, passing out

Specific symptoms for this student may include: _____

_____

All above symptoms can potentially progress to a life-threatening situation. The severity of symptoms can quickly change.

ACTION:

- ☐ If ingestion is suspected
- ☐ If stung by bee
- ☐ Experienced other life threatening allergy
  - Inject: ___ Epi Pen ___ Epi-Pen Jr. **
  - Call 911
  - Call: ___ Mother(_____) ___ Father(_____) or ___ emergency contact
  - Call: Dr._____ at _____
  - Continue to monitor student for absent breathing/pulse until EMT arrives.
  - Initiate CPR if pulse and/or breathing absent
  - Offer reassurance to student, as appropriate

*** Give used epi-pen to EMT*

_____ _____

Parent Signature Date

_____ _____

Doctor's Signature Date

Epi-3

MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

Parent/Guardian Signature Date

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date_____

Pharmacy _____ Phone _____

Name of Medication_____

Name of Physician _____ Phone _____

Of Tablets Received _____

****

PHYSICIAN'S ORDERS

Name of Patient_____

Name of Medication_____

Date of Prescription_____

Dosage_____

Purpose_____

COMMENTS_____

_____

Doctor's Name (please print) Doctor's Signature Date

Please Print

Name: _____ **Grade:** _____

Allergy: _____

Medication: _____

Emergency Contacts:

1. _____ **Phone:** _____ **Relationship:** _____

2. _____ **Phone:** _____ **Relationship:** _____

3. _____ **Phone:** _____ **Relationship:** _____

Doctor: _____ **Phone:** _____

Parent/Guardian Signature: _____

Epipen