

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE AUTO-INJECTOR AT SCHOOL

Student Name: _____ DOB: _____ Grade: _____
Emergency Contacts: (Name and Phone#s): _____

I. Parental/Guardian Consent for Delegate Administration of Epinephrine Auto Injector

I hereby acknowledge my understanding that if the procedures outlines in P.L. 2007, c.57 and "TRAINING PROTOCOLS FOR THE EMERGENCY ADMINISTRATION OF EPINEPHRINE " issued by the NJ Department of Education are followed, the school district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto injector containing epinephrine and the parent/guardian shall indemnify and hold harmless the school district and its employees or agents against any claims arising from the administration of a pre-filled single dose auto injector containing epinephrine to the student. The school nurse shall designate, in consultation with the Board of Education, additional employees of the school district to administer epinephrine via auto-injector to my child for anaphylaxis or possible anaphylaxis when the school nurse is not physically presents at the scene, as specified in P.L. 2007, c.57.

____ I approve having delegate(s) assigned for my child. I understand that a list of my student's delegates is available for review in the Nurse's office.

____ I decline delegate administration of epinephrine for my child.

Parent/Guardian Name Signature Date

II. Parental/Guardian Consent for Student Self Administration of Epinephrine Auto Injector and Antihistamine:

____ I request that my child be ALLOWED to carry the prescribed medication for self-administration in school and on off-site school related activities pursuant to N.J.S.A.:18A:40-12.3-12.6. I give permission for my child to self-administer medication, as prescribed on this form for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

____ I do not allow my child to carry and self-administer epinephrine auto- injector and antihistamine

Parent/Guardian Name Signature Date

III. Healthcare Provider's Order: (please check all applicable lines)

The above student has a potentially life threatening allergy that could result in anaphylaxis and

The Student's potential triggers of Anaphylaxis are: _____

The Student is an Asthmatic _____ Yes _____ No

The Student's possible symptoms of Anaphylaxis are: _____

Or _____ possible symptoms are unknown at this time but student is at risk for future anaphylaxis.

In case of possible anaphylaxis administer: (Please DO NOT prescribe TwinJet® products for school use)

____ Epinephrine auto-injector 0.3mg up to 2 doses as needed

____ Epinephrine auto-injector 0.15mg up to 2 doses as needed

*Please note our school standing orders allows a nurse to administer an equivalent dose of epinephrine via ampule and syringe

____ School nurse may administer a single oral dose of Diphenhydramine: _____ mg

____ Student may self-administer epinephrine auto-injector as prescribed above. This student has been instructed in and is capable of proper method of self-administration of epinephrine auto-injector. This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____ Student may self-administer a single oral dose of Diphenhydramine: _____ mg

____ This student is not approved to self-medicate with an epinephrine auto-injector or Oral Diphenhydramine

Physician's Name Signature Date

Physician's Office Stamp:

Approved by School Nurse (signature and date): _____

Approved by School MD (signature and date): _____

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

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue 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 or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or 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: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

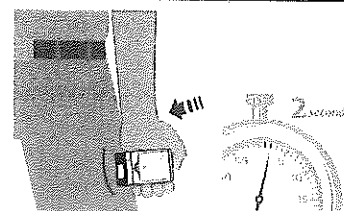
Antihistamine Dose: _____

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

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

3



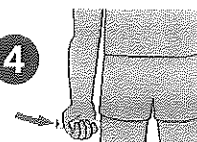
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

3



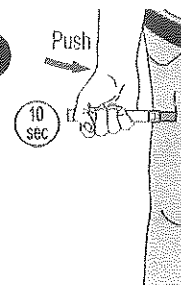
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HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

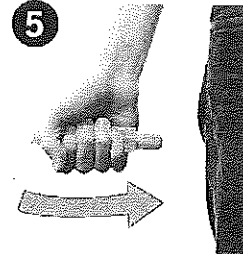
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HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5



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: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Clinton Township School District: **Allergy Information/History**

Date _____

Student Name _____

DOB _____ Grade _____

Known Allergy to Food, Insects, Bees, Latex, Medications etc...

1. List Known Allergies:

Severe Allergy: _____

Mild Allergy: _____

2. Medications kept on hand in case of an allergic reaction:

3. Has the child had allergy testing to determine the severity of the allergen?
When? When is follow-up testing planned?

4. History: When diagnosed?

Describe the reaction experienced when the allergy was diagnosed.

5. Has the child experienced a true anaphylactic reaction? _____, if so,
describe: Cause of reaction, signs and symptoms, actions needed to treat the
reaction including administration of Benadryl/Epinephrine auto-injector,
emergency room or physician office visit.

6. List restrictions:

Describe the child's awareness of his/her restrictions concerning exposure to the
allergen:

CLINTON TOWNSHIP SCHOOL DISTRICT

EMERGENCY TRANSPORTATION PLAN

PUT PICTURE HERE

Date _____

Student Name _____ DOB _____ GR _____

Address _____

Pickup Bus _____ Departing Bus _____

Parent(s) _____ Home Phone _____

Father Work _____ Mother Work _____

Pager/Cell _____ Pager/Cell _____

Doctor _____ Phone _____

Medical Condition:

This student has a history of a severe allergy to _____, which could cause anaphylaxis to occur.

Anaphylaxis is a severe allergic response that occurs when a person is exposed to an allergy-causing substance.

Signs and symptoms include: hives or rash, swelling of the face and/or extremities, tingling of the lips and mouth, tightening of the throat, flushing of the face or body, cough, wheeze, shortness of breath, nausea, vomiting, increased heart rate, low blood pressure and fainting.

Signs of Emergency: any of the above

Precaution: DO NOT allow eating on the bus.
Sit near front of bus.

Actions for bus driver to take:

1. Stop the bus
2. Call 911. Ask for paramedics and state that you have a student with the following condition _____.
3. Have Transportation Office notify home and/or school. Parent and School Nurse may be able to meet bus at location.
4. Transport student by rescue squad to Hunterdon Medical Center Emergency Department.