PARSIPPANY TROY-HILLS TOWNSHIP SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION

My child _____, date of birth _____, is in need of _____ medication during school hours/school sponsored events. I am requesting that the above medication be administered to my child as described in the written Health Care Provider's order, and according to Parsippany Troy-Hills district policy.

This request is effective for the _____ school year only.

_____ _____
Principal's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Parent's Signature Date

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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: ☐ 0.01 mg IM ☐ 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

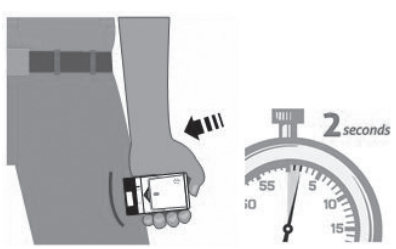
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

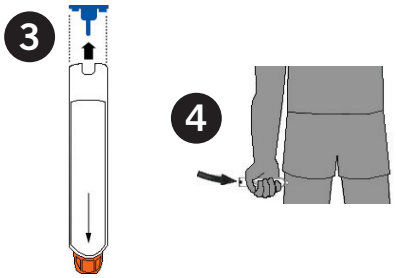
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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.



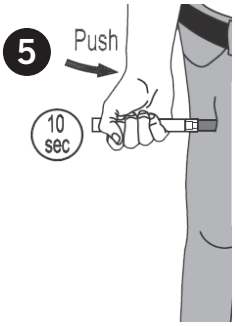
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), 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.



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) 5/2018

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

SELF-ADMINISTRATION/SELF CARRY OF MEDICATION
(ALLERGIC REACTION/ASTHMA/INSULIN)

Dear Parent/Guardian:

Please have your child's physician complete the form as it appears and return it to the school nurse as soon as possible.

1. Pupil's name _____
2. Diagnosis _____
3. Name of medication _____

   PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse. Thank you.

4. Dosage _____
5. Route _____
6. Time to be administered _____
7. Special instruction _____
8. Side effects _____

I certify that the above-mentioned child is capable of, and has been instructed in, the proper method of self-administration of the medication as is indicated above.

_____ _____
Physician's Signature Date

Please print, type or stamp

Physician's Name: _____

Address: _____

Telephone: _____

License No.: _____

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I acknowledge that the Parsippany-Troy Hills School District shall incur no liability as a result of any injury arising from my child holding in his physical possession and the self-administration of the above mentioned medication, and I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the holding and self-administration of this medication.

This permission is effective for the current school year only and will be reviewed each subsequent school year if the medication needs to be continued.

_____ _____
Parent's Signature Date

SN# 4
3/16

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

PARENT'S CONSENT FOR TRAINED DELEGATE TO ADMINISTER EPINEPHRINE VIA PRE-FILLED AUTO-INJECTOR MECHANISM

Attention School Nurse:

In the event that the school nurse is unavailable, I give permission for a designee, selected and trained by the school nurse, to administer Epinephrine via pre-filled auto-injector mechanism to my child _____, grade _____, if an emergency situation indicating the need for it should arise.

I understand that the school district, its employees or agents, shall have no liability as a result of any injury arising from the administration of Epinephrine to the pupil, and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of Epinephrine to my child.

This permission is effective for this school year _____ only.

_____
Parent's Signature

_____
Date

OR

I do **NOT** give permission for a designee to administer Epinephrine via a pre-filled auto injector mechanism to my child in the event that my child should exhibit untoward symptoms due to an allergic reaction.

_____
Parent's Signature

_____
Date

SN#8
3/16