Place Child's Picture Here

PRINCETON REGIONAL SCHOOLS
ALLERGY ACTION PLAN
Part A: Physician Order

School Year _____

Student's Name: _____ D.O.B: _____ Grade/Teacher:_____

ALLERGIC TO:

Previous episode of anaphylaxis: YES* (_____) NO (_____)

Asthmatic: YES* (____) NO (_____) * High risk for severe reaction

Does child require allergy free table in cafeteria? YES (_____)* NO (_____)

SIGNS OF AN ALLERGIC REACTION

Systems:	Symptoms:
Mouth	Itching & Swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness in the throat, horsensess, and hacking cough
Skin	hives, itches rash, and/or swelling about the face or extremities
Gut	nausea, abdominal, cramp, vomiting, and/or diarrhea
Lung	shortness of breath, repetitive coughing, and/or wheezing
Heart	"thready" pulse, "passing-out"

TO BE COMPLETED BY HEALTHCARE PROVIDER

To maintain/protect the health of the above named student, the emergency administration of Epinephrine for anaphylaxis is required.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg
(MD to order) **(Designee CANNOT give Twinject)**

Repeat Dose if necessary: (circle) Y N **(Designee CANNOT give a second dose)**
(MD to order)

Antihistamine: give _____
(MD to order) (medication/dose/route)
Designee CANNOT administer Antihistamine

MD to initial, which applies:

_____This student **must carry** his/her Epinephrine during the school day and **is capable of self administration.** He/she has received instruction in the proper use of the epinephrine. In the event this student may not have the capacity for self-administration, the nurse or designee (s), delegated and trained by the school nurse, will administer the medication.

_____This student does not have the capacity for self-administration of epinephrine. He/she **may only carry this medication.** The emergency administration of epinephrine will be performed by a nurse and /or designee(s), delegated and trained by the nurse. Transportation will be notified).

_____This student does not have the capacity for self-administration of epinephrine and **will not carry this medication.**

_____ _____

Signature of Physician Date Address

_____ _____

Printed Name (STAMP) Phone Number

BOTH SIDES OF FORM MUST BE COMPLETED

PRINCETON REGIONAL SCHOOLS
ALLERGY ACTION PLAN
Part B: Parents/Guardians
EMERGENCY CALLS

1. Call 911 (State that an allergic reaction has been treated, and additional epinephrine may be needed.)

2. Parent/Guardian: 1st _____ 2nd _____3rd _____

Parent/Guardian: 1st _____ 2nd _____3rd _____

3. Emergency contacts (name/relationship): Phone Number(s)_____

a) _____ 1)_____ 2)_____

b)_____ 1)_____ 2)_____

To maintain/protect the health of _____, the emergency administration of epinephrine for anaphylaxis is required.

Parent/Guardian to initial which best applies:

_____ My child is **capable of self-administration** and has been instructed in the emergency Self-administration of his/her prescribed medication. He/she **must carry his/her medication** during the school day. I hereby give permission for my child to self-administer his/her prescribed medication.

_____ My child is unable to self-administer his/her prescribed medication but may carry the prescribed medication for administration by a nurse or designee. I hereby request the school nurse or designee(s) to administer the prescribed medication to my child in the event of an emergency. I understand that a designee will not administer antihistamines.

Circle one: The Epi-pen will be carried in: Backpack or Other_____

_____ My child is **unable to self-administer or carry** his/her prescribed medication and hereby request that he/she only receive his/her prescribed medication by a school nurse or designee.

_____ My child is a student between the grades of K-6. I authorize and will provide back-up, pre-filled auto-injector(s) of epinephrine to be strategically placed in the school for my child, at the discretion of the nurse, based on my child's classroom(s) throughout the typical school day.

Please sign:

I give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

_____ _____
Parent/Guardian Signature Date

I give permission for the school nurse to release information about my child's allergies to:
Please check:

Faculty_____

Cafeteria Staff_____

Bus Driver_____

We shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration or emergency administration of medication by the pupil or designee as long as procedure is followed.

This form is only valid for one school year and must be renewed annually.

_____ _____
Parent/Guardian Signature Date

_____ _____
School Nurse Signature Date