DEMAREST PUBLIC SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT
School Year _____

Student's Name: _____Birth Date_____ Grade_____

The above student is allergic to: _____

Previous episode of anaphylaxis: Yes ☐ No ☐ **Asthmatic : Yes ☐ No ☐**

MEDICATIONS

ANTIHISTAMINE: Name: _____Dose_____

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 _____

EPINEPHRINE:

☐ EpiPen ☐ EpiPen Jr. ☐ Auvi Q 0.3 ☐ Auvi Q 0.15 ☐ Other _____

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 _____

Choose one administration order:

☐ Give Antihistamine only – Delegate can not be assigned*
☐ Give Epinephrine immediately – Delegate will be assigned
☐ Give Antihistamine and Epinephrine immediately – Delegate will be assigned in the absence of the nurse
☐ Give Antihistamine first, observe for further symptoms and give epinephrine PRN – Delegate will be assigned in the absence of the nurse.

***Please note – in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded.**

This student has been trained and is capable of self-administration of the following medication(s) named above. ☐ Epinephrine – single dose unit. ☐ Epinephrine & antihistamine-single dose units

*Under NJ state law, orders for antihistamine alone CANNOT be self administered.

☐ This student is not capable of self-administration of the medications named above.

Physician's signature _____ Physician's Stamp

Phone Number _____Date _____

Parents/Guardians
A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container. It is the responsibility of the Parent/Guardian to replace the auto-injector and antihistamine when they reach their expiration date.

Select one to sign and date

1. I verify that my child_____ has a potentially life threatening illness and **has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self-administer prescribed medication**. I further acknowledge that the Demarest School District shall incur no liability as a result of any injury arising from the self- administration of medication by my child. If procedures specified by N.J.S.A. 18A:40-12.3 and the Demarest School District Policy are followed, I shall indemnify and hold harmless the Demarest School District and its employees or agents against any claims arising out of self administration of medication by my child.

_____ _____
Signature of Parent/Guardian Date

2. I verify that my child_____ has a potentially life threatening illness and is **unable to self-administer** the prescribed medication in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Demarest School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by N.J.S.A. 18A:40-12.5 and the Demarest School District Policy are followed, I shall indemnify and hold harmless the Demarest School District and its employees or agents against any claims arising out of administration of medication to my child.

_____ _____
Signature of Parent/Guardian Date

Please sign
I understand that under NJ State law, a trained delegate will be assigned to administer epinephrine to my child **in the absence of a school nurse**. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. I shall indemnify and hold harmless Demarest School District and its employees or agents against any claims arising out of administration of medication.

_____ _____
Signature of Parent/Guardian Date

Permission is effective for the school year for which it is granted and needs to be renewed for each subsequent school year.

10/15