WOODLAND TOWNSHIP BOARD OF EDUCATION
CHATSWORTH ELEMENTARY SCHOOL
2 John Bowker Jr. Blvd – PO Box 477
Chatsworth, NJ 08019
PH: (609) 726-1230 F: (609) 726-9037

ALLERGY ACTION PLAN

School Year: 20___- 20___ Grade: _____

Name of Child: _____ D.O.B. _____

ALLERGIC TO: _____

STEP 1: TREATMENT To be completed by Physician

-Has had an anaphylactic reaction in the past ____YES ____NO

-If yes, when and what where the symptoms _____

-Student Asthmatic ____YES* ____NO *High risk for severe reaction

Symptoms:	Give Checked Medication:
☐ If child exposed to allergen, but *no symptoms*	__ Epinephrine __ Antihistamine
☐ Mouth: Itching, tingling, or swelling of lips, tongue, mouth	__ Epinephrine __ Antihistamine
☐ Skin: Hives, itchy rash, swelling of the face or extremities	__ Epinephrine __ Antihistamine
☐ Gut: Nausea, abdominal cramps, vomiting, diarrhea	__ Epinephrine __ Antihistamine
☐ Throat: Tightening of throat, hoarseness, hacking cough	__ Epinephrine __ Antihistamine
☐ Lung: Shortness of breath, repetitive coughing, wheezing	__ Epinephrine __ Antihistamine
☐ Heart: Thready pulse, low blood pressure, fainting, pale blueness	__ Epinephrine __ Antihistamine
☐ Other: _____	__ Epinephrine __ Antihistamine
☐ If reaction is progressing (several of the above areas affected), give	__ Epinephrine __ Antihistamine

DOSAGE

Epinephrine: give _____
Medication /Dose /Route

Antihistamine: give _____
Medication /Dose /Route

Other: give _____
Medication /Dose /Route

___This student is capable and has been instructed in the proper method of self-administering epinephrine using an autoinjector and may self-medicate.

___This student may not self-medicate.

Physician Name: _____ Signature: _____ Date: _____

STEP 2: EMERGENCY CONTACTS To be completed by parent

1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor: _____ Phone Number: _____
3. Parent: _____ Phone Number: _____
4. Emergency Contacts - Name/Relationship and Phone Number(s)

a. _____

b. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent Name: _____ Signature: _____ Date: _____

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PHYSICIAN'S PERMISSION FOR DELEGATING THE ADMINISTRATION OF EPINEPHRINE VIA A PRE-FILLED, SINGLE DOSE AUTO-INJECTOR MECHANISM

School Year: 20___ - 20___ **Grade:** _____

Name of Child: _____ **D.O.B.** _____

Anaphylactic Allergy to:

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

I certify that this student suffers from a life threatening reaction to the allergen(s) listed above, and does not have the ability to self-administer an injection of epinephrine. I understand that there may be times, such as a field trip or an extracurricular event, that a school nurse is not available to this child. In these cases the school may elect to train a delegate to administer an Epi-Pen or an Epi-Pen Jr so that this child would always be accompanied by someone to administer this life saving drug.

If there is reasonable suspicion the above named child has been stung or has ingested the above named allergen, or if any of the 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, and diarrhea; shortness of breath, wheezing or hacking cough; thready pulse or passing out.

1. ___ Administer immediately: ☐ the Epi-Pen (.3mg) subQ or IM
   ☐ the Epi-Pen Jr. (.15) subQ or IM

   ___ Administer only if signs of anaphylaxis develop:
   ☐ the Epi-Pen (.3mg) subQ or IM
   ☐ the Epi-Pen Jr. (.15mg) subQ or IM
2. Call 911 and parent immediately.
3. Begin CPR if pulse or breathing absent.
4. Make child as comfortable as possible until ambulance arrives.

Physician's signature: _____ Office Stamp:

Date : _____

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

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PERMISSION FOR SELF-ADMINISTRATION OF MEDICATON FOR EPINEPHRINE VIA AUTO-INJECTOR FOR ANAPHYLAXIS

School Year: 20___ - 20___ **Grade: _____**

Name of Child: _____ D.O.B._____

Completed by Physician

Diagnosis/Allergy(s):_____

Medication:_____

Dose and Frequency:_____

Indication for use:_____

Side Effects:_____

I verify that the above named student has been adequately trained in the use of his/her medication, therefore, is capable of carrying and self-administering the above named medication for anaphylaxis provided that the pupil does not endanger him/herself or other persons through misuse.

Physician Name:_____ Signature:_____ Date_____

Physician Telephone Number:_____

Physician Address:_____

Completed by Parent/Guardian

Agreement for Self-Administration of Medication

I request that my child be permitted to carry and self –administer their medication for anaphylaxis as listed above. I verify that I have observed my child technique on self-administering his/her medication and is competent to do so. In signing this form I acknowledge that the Southampton Township School District shall incur no liability as a result of injury arising from the self-administration of medication for anaphylaxis. I shall indemnify and hold harmless the Southampton Township School District and its employees, including school nurse, or any other officer or agents of the board of education against any claims, arising out of the self-administration of medication by my child.

Parents: the following guidelines will be used for the self –administration of epinephrine via auto-injector:

1. This request for self-administration of epinephrine for anaphylaxis must be done annually for each school year.
2. Parents should instruct their child to keep the medication for anaphylaxis with them at all times and labeled with name and allergy. Parent is to supply ALL medications.
3. It is recommended that "back up" medication be kept in the Nurse's Office.
4. Parents are to instruct their child that whenever they self-administer their medication they are to inform teacher, coach, or other individual in charge and 911 will be called. Also nurse needs to be informed.

Parent/Guardian Name:_____ Signature:_____

Parent/Guardian Name:_____ Signature:_____

Date of Agreement::_____

Chatsworth Elementary School
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Consent and Release for Administration of Epinephrine

Name of Student: _____

1. I hereby request and authorize the school nurse, medical director, or in their absence, a designee or designees who are employees of Woodland Township Board of Education to administer epinephrine via epi-pen to my child for anaphylaxis.

2. The district shall have no liability as a result of injury arising from administration of the epi-pen by the school nurse or designee(s) to the pupil. The district, it's employees, and agents shall be indemnified and held harmless against any claims arising out of the administration of epi-pen to this child.

3. This Consent and Release shall remain in full force for one full year.

Signature _____ Date: _____