

**MORRIS HILLS REGIONAL DISTRICT  
EMERGENCY HEALTH CARE PLAN  
FOR ALLERGIC REACTIONS  
2024-2025 Academic Year**

**Contact Information to be completed by parent/guardian**

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

**Emergency Contacts:**

First Contact Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Second Contact Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

**Allergy To** \_\_\_\_\_ **Asthmatic** Yes ☐ No ☐ Inhaler \_\_\_\_\_

**IF EXPOSED TO AN ALLERGEN: TO BE COMPLETED BY PHYSICIAN/ADVANCED PRACTICE NURSE**

Has student received epinephrine for anaphylaxis (date) \_\_\_\_\_ yes \_\_\_\_\_ no

Has the student been tested? yes \_\_\_\_\_ no \_\_\_\_\_

Has student undergone insect sting desensitization? yes \_\_\_\_\_ no \_\_\_\_\_

Does student have medic alert bracelet? yes \_\_\_\_\_ no \_\_\_\_\_

<b>Symptoms:</b>		<b>Give Checked Medication</b>	
• If a food allergen has been ingested, but no symptoms:		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Throat	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Lung	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Heart	Weak or thready pulse, low BP, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Other	_____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected), give:		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

**Please note-in the absence of a school nurse, a trained delegate will give epinephrine only.**

**Dosage:**

Epinephrine: inject intramuscularly (circle one) EpiPen JR 0.15mg EpiPen 0.3mg Twinject 0.3mg

Twinject 0.15mg Auvi-Q 0.3mg

**Epinephrine** may be repeated in \_\_\_\_\_ minutes. (by RN only)

**Antihistamine:** (given concomitant/Epinephrine) \_\_\_\_\_ (by RN or self-medication only)

**Emergency Procedure**

1. Administer epinephrine via auto injector mechanism
2. Call 911 and state that a student has an allergic/anaphylactic reaction and request that paramedics transport the student to the nearest hospital.
3. Notify parents/guardians.

**Student Education**

I certify that the student has been instructed on purpose and how to self administer this medication with assistance if necessary. In the event the student is exposed at school or a school sponsored event to the allergen the School Nurse or designee will administer the medication

**Physician Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Stamp or name, address and phone printed:**

\_\_\_\_\_

\_\_\_\_\_

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## SECTION I – TO BE COMPLETED BY PARENT/GUARDIAN

### A. Parent Authorization (to be completed for all students).

I hereby give permission for my child to receive emergency epinephrine medication at school as prescribed above. I also give permission for the release and exchange of information between the school nurses and my child's health care provider concerning my child's health and medication. In addition, I understand that this information will be shared with school staff on a need to know basis.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

### B. Parent authorization for the administration of epinephrine by delegates.

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates trained by the certified school nurse to administer epinephrine in the event that the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to a student via a pre-filled auto-injector mechanism. **In addition, I will notify the school at least 24hrs in advance if my child is going to attend a school sponsored event (please refer to handbook). In the event this does not occur I understand that a delegate may not be present to administer emergency epinephrine if necessary.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

### C. Parent Authorization

1. I understand my child has been instructed on how to self-administer medication as prescribed. I consider him/her to be responsible and capable of self-administration of medication but in the event my child is exposed at school or a school sponsored event to the allergen the School Nurse or designee will assist and/or administer the medication. Medication must be kept in its original prescription container.
2. I understand my child is to keep the medication for administration with him/her at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre-measured dose of antihistamine, in its original labeled container, is to be kept with the student, along with epinephrine, at all times.
3. I understand that the district and its employees or agent shall incur no liability as a result of any injury arising from the self-administration by the student of the medication prescribed on this form and that I indemnify and hold harmless the district and its employees or agent against any claims arising out of the self-administration of medication by the student.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

## SECTION 111 – TO BE COMPLETED BY STUDENT AND PARENT

### A. Student Education on Self-Administration.

I understand and I will use this medication as directed by my physician. I will be responsible in carrying and using this medication as described while in school, on field trips and at school sponsored events. I have been instructed on how to self-administer this medication and understand the side effects of improper use.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature

### B. Student Agreement for Delegate.

I understand that I will be assigned a delegate at school sponsored events. If I come into contact with an allergen I will notify an adult/delegate immediately who will assist and/or administer the medication.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature