Morris Hills Regional High School District
Morris Knolls High School
Parent Consent for Self-Administration/Delegation

According to District Policy 5330, SELF-ADMINISTRATION of any medications by school children is not permitted except in the cases of potentially life-threatening illness. State law requires that the school must have written authorization from the physician and the parent or guardian for a student to carry and administer their emergency medication on school grounds. The school nurse may not be available for all school-sponsored activities or events, therefore a delegate trained by the school nurse will be available.

Permission for medication administration is effective only for the current school year and needs to be renewed for each subsequent school year.

I request that my child be permitted to self-administer their emergency medication as prescribed. If my child is unable to administer his/her medication and is not in school or is in school after school hours, a trained delegate may administer the medication.

Name: _____

Grade: _____

Medication: _____

I acknowledge that the Morris Hills Regional High School District Board of Education shall incur no liability as a result of any injury arising from self-administration of medication by the pupil or a delegate, and that we, the parents, shall indemnify and hold harmless the district and it's employees against any claims arising out of the self-administration of medication by the pupil.

Parent/Guardian Signature: _____ Date: _____

***My child no longer needs emergency medication in school.* _____
Parent/Guardian Signature/Date

MORRIS HILLS REGIONAL DISTRICT
EMERGENCY HEALTH CARE PLAN
FOR ALLERGIC REACTIONS

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

Symptoms:		**Give Checked Medic**	
If a food allergen has been ingested, 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	Weak or thready pulse, low BP, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
Other	_____	□ Epinephrine	□ Antihistamine
If reaction is progressing (several of the above areas affected), give:		□ Epinephrine	□ 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

Administer epinephrine via auto injector mechanism
Call 911 and state that a student has an allergic/anaphylactic reaction and request that paramedics transport the student to the nearest hospital.
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:

_____

_____