



**Administration of Epinephrine
to a Student by a Delegate**

In accordance with New Jersey Law P.L 2007, Chapter 57, the Mount Laurel Township Board of Education policy on the administration of medication to a pupil provides that the school nurse shall have the primary responsibility for the administration of epinephrine. The school nurse shall designate, in consultation with the Board of Education additional employees of the school district who volunteer to administer epinephrine via a pre filled auto-injector mechanism to a pupil for anaphylaxis when the nurse is not physically present at the scene. The school nurse shall determine that:

- a. The designees have been properly trained in the administration of the epinephrine via a pre-filled auto injector mechanism.
- b. The parents or guardians of the pupil consent in writing to the administration of the epinephrine by a designee.
- c. The Board of Education shall inform the parents or guardians of the student in writing that the district and its employees shall have no liability as a result of any injury arising from the administration of the epinephrine to the student.
- d. The parents or guardians of the student sign a statement acknowledging their understanding that the district shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector to a student and that the parents or guardians shall indemnify and hold harmless the district and its employees any claims arising out of the administration of the epinephrine to a student.
- e. The permission is effective for the school year for which it is granted and must be renewed for each subsequent school year.

The permission form on the reverse side is for permission for a delegate to administer epinephrine via auto injector to the designated student. There is a separate form that must be completed to allow the school nurse or her substitute to administer the epinephrine. This second form allowing the nurse to administer the epinephrine also allows for administration of an antihistamine, if so ordered by a physician and approved by the parent/guardian. A delegate **MAY NOT administer an antihistamine (i.e. Benadryl).**

Medications must be brought to school in the original labeled pharmacy container by an adult. The epinephrine auto injectors will be stored in a secure unlocked location, easily accessible to the nurse and school delegates while school is in session and during school sponsored functions.

****SEE REVERSE SIDE FOR DELEGATE PERMISSION FORM****

Medication Permission for Administration of Epinephrine
by a Delegate

****Please note that a delegate may NOT give an antihistamine, therefore the physician's order must note the specific symptoms and / or events (i.e. ingestion of peanut) as to when the delegate should administer the epinephrine****

School Year _____ Class _____

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

Student is allergic to: _____

Student is asthmatic: _____ Yes _____ No

Check off the appropriate times the delegate should administer epinephrine in the dose indicated below. (This must be completed for delegate order to be in effect.)

_____ If a food allergen has been ingested, but no symptoms. Name the allergen(s):

_____ If stung or bitten by an insect, but no symptoms. Name the allergen(s):

_____ Mouth: itching, tingling, swelling of lips, tongue, mouth
_____ Skin: hives, itchy rash, swelling of the face and or extremities
_____ Throat: tightening of throat, hoarseness, hacking cough
_____ Gut: nausea, abdominal cramps, vomiting, diarrhea
_____ Lung: shortness of breath, repetitive coughing, wheezing
_____ Heart: thready pulse, fainting, pale, blueness
_____ Other: _____

Epinephrine (Brand/Dose) _____

Possible side-effects: _____

After administration of epinephrine, the delegate will: call 911 and monitor patient until EMS arrives.

NAME OF PHYSICIAN (PRINTED)

SIGNATURE OF PHYSICIAN

TELEPHONE NUMBER OF PHYSICIAN

DATE

I hereby give permission for my child's delegate(s) to administer the above medication to my child named above. I shall provide this medication in its original container, properly labeled from the pharmacy/store. I release the Mt. Laurel Township Board of Education and its employees from any liability concerning the administration of such medication to my child.

PARENT/GUARDIAN SIGNATURE

DATE

Food Allergy Action Plan

Emergency Care Plan

Place
Student's
Picture
Here

Name: _____ D.O.B.: ____/____/____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

Extremely reactive to the following foods: _____

THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

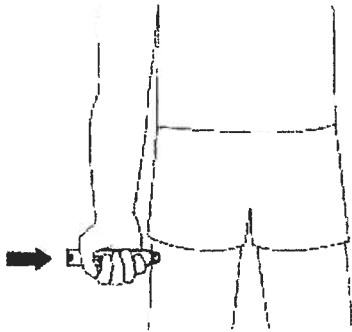
Date _____

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
- Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

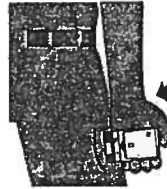
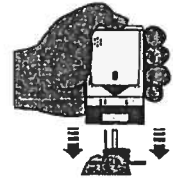


EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty LP.

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.



Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

© 2002-2013 sanofi-aventis U.S. LLC. All rights reserved.

Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 • Rescue squad: (____) _____ - _____ Doctor: _____ Phone: (____) _____ - _____
Parent/Guardian: _____ Phone: (____) _____ - _____

Other Emergency Contacts

Name/Relationship: _____ Phone: (____) _____ - _____
Name/Relationship: _____ Phone: (____) _____ - _____