

**BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES
PHYSICIAN'S ORDERS FOR
ALLERGY EMERGENCY TREATMENT**

Student Photo

Student Name: _____ **Date of Birth:** _____

Teacher/Team: _____ **Grade:** _____

Diagnosis: is allergic to: _____

Previous episode of anaphylaxis: Yes No

If yes, please explain: _____

History of asthma: Yes No

Antihistamine: Name: _____ Dosage: _____

Nurse only: Give the above antihistamine for the following checked symptoms:

Skin - hives, itchy rash

Other: _____

Epinephrine Auto-injector: EpiPen Auvi-Q 0.3mg dose 0.15mg dose

Give epinephrine in the dose checked above one time or

Repeat the above dose of epinephrine in _____ min. if symptoms persist. **(PLEASE NOTE: THE**

DELEGATE CAN ONLY GIVE A SECOND DOSE OF EPINEPHRINE IF THIS BOX IS CHECKED.)

Give epinephrine in the dose checked above for the following checked 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 Epinephrine only. * **(Delegate will be assigned to administer epinephrine in absence of nurse)**

Give Antihistamine and Epinephrine at the same time.

Give Antihistamine first, observe for further symptoms and give epinephrine PRN.

* **PLEASE NOTE: IN THE ABSENCE OF THE SCHOOL NURSE, ANY ANTIHISTAMINE ORDER WILL BE DISREGARDED AND A TRAINED DELEGATE WILL GIVE THE AUTO-INJECTABLE DOSE OF EPINEPHRINE.**

This student has been trained and is capable of self-administration of the following medications:

Epinephrine – single unit dose of _____mg

Epinephrine – 2 unit dose _____mg. 2nd dose may be repeated in _____ minutes if symptoms persist and progress

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

This student carries an EpiPen/Auvi-Q on his/her person.

Physicians Signature

Physician's Phone Number Date

Physician's stamp or print name

PARENTS: PLEASE COMPLETE REVERSE SIDE

PARENTS/GUARDIANS:

An Epinephrine auto-injector must be provided to the school for your child's use. If your physician requested that the epinephrine be repeated if symptoms persist, then a second auto-injector must be provided. Antihistamines and epinephrine must be brought to school by an adult and must be provided in the original labeled pharmacy container. Please check that the medication provided is current and not expired.

Please read, sign and date the following:

I verify that my child, _____, has a potentially life-threatening illness. I hereby give permission for the school nurse to administer Epinephrine to my child as prescribed by my child's physician. I request that delegate/s be trained to administer Epinephrine to my child and I give the delegate/s permission to administer Epinephrine to my child as prescribed by my child's physician. I further acknowledge that the Branchburg Township School district incur no liability as a result of any injury arising from administration of this medication to my child and shall indemnify and hold harmless the Branchburg Township School District and its employees or agents against any claims arising out of administration of this/ these medications to my child.

Parent/Guardian Signature _____
Date

PARENTS/GUARDIANS CONTACT INFORMATION: Home phone number: _____

Mother's cell number: _____ Mother's work number: _____

Father's cell number: _____ Father's work number: _____

Please read, sign and date the following:

In the absence of a school nurse, I hereby give permission to the delegate/s trained by the school nurse to administer epinephrine as prescribed by my child's physician. I understand antihistamines cannot be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and only epinephrine will be administered by the trained delegate.

Parent/Guardian Signature _____
Date