

Bernards Township Public Schools

Life Threatening Allergy EMERGENCY HEALTH CARE PLAN

Place
Childs
Picture
Here

Name: _____ D.O.B.: _____ Grade/Teacher: _____

Allergy To: _____

Asthmatic: Yes No *High Risk for severe reaction

◆STEP 1: TREATMENT◆

SYMPTOMS

GIVE CHECKED MEDICATION

** (To be determined by physician authorizing treatment)

If the allergen has been ingested/ contacted but no symptoms	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
MOUTH Itching and swelling of the lips, tongue or mouth	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
SKIN Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
STOMACH Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
THROAT* Tightening of, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
LUNG* Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
HEART* Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
OTHER _____	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine
If a reaction is progressing (Several of the above areas affected), give	<input type="checkbox"/> Epinephrine	or	<input type="checkbox"/> Antihistamine

The severity of these symptoms can quickly change. *Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) **EpiPen® EpiPenJR® Twinjet 0.3mg™ Twinjet 0.15mg™**

Antihistamine: give _____
Medication / Dose / Route

Other: give _____
Medication / Dose / Route

I have certified that this child is capable of self administering this medication ____ **NO** ____ **YES**

◆**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis**

◆STEP 2: EMERGENCY CALLS◆

1. CALL 9-1-1: State that an allergic reaction has been treated, and additional epinephrine may be needed

2. CALL Mother: _____ **Father:** _____

EVEN IF PARENTS OR DOCTORS CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

I hereby request and authorize appropriate Bernards Township Public School employees to administer prescribed medication as directed by the undersigned licensed health care provider. I grant permission for Bernards Township Public School employees to exchange information with my child's health care provider as deemed necessary.

Parent's Signature _____ Date _____

PHYSICIAN STAMP
(Must be present for plan to be valid)

Physician Signature _____ Date _____

School Nurse Signature _____ Date _____

**BERNARDS TOWNSHIP PUBLIC SCHOOLS
NURSE'S OFFICE**

Indemnification / Hold Harmless Self Administration

My child _____ has been instructed by _____
(Child's Name) (Name of Healthcare Provider)

in the proper administration of _____
(Name of Medication)

It is my belief that _____ is capable of using this medication appropriately and independently.
(Child's Name)

I am requesting that _____ be permitted to carry _____
(Child's Name) (Name of Medication)

and self-administer it as needed. I have instructed _____ to inform the school nurse if this
(Child's Name)

medication has been self-administered during school hours or the district delegated person in charge of school sponsored activities.

I furthermore agree to the indemnification agreement contained below:

The parent of guardian agrees to indemnify, defend, and hold the school district harmless for any and all claims, actions, costs, expenses, damages, and liabilities, including attorney fees, arising out of, connected with, or resulting from the self-administration of medication by the pupil.

The parent or guardian agrees to extend this indemnification/hold harmless agreement to the Board of Education, Board of Education employees, and its agents. The parent or guardian agrees the school district, Board of Education, Board of Education employees, and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be renewed for each subsequent school year. This agreement must be signed and in full effect prior to the granting of permission of self-administer medication.

Parent / Guardian's Signature

Date

School Nurse's Signature

Date

Date of Agreement (Date of Full Effect) _____