ANAPHYLAXIS ACTION PLAN

Name of Student: _____

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

ALLERGY TO: _____

ASTHMATIC: [ ] Yes^ [ ] No (^*Higher Risk for Severe Reaction*)

Place Child's Picture Here

STEP 1: TREATMENT

SYMPTOMS:

GIVE CHECKED MEDICATION^^:
(^^*To be determined by physician authorizing treatment*)

a.	If a food allergen has been ingested, but ***no symptoms***	a. [ ] Epinephrine	[ ] Antihistamine
b.	Mouth — Itching, tingling, or swelling of lips, tongue, mouth	b. [ ] Epinephrine	[ ] Antihistamine
c.	Skin — Hives, itchy rash, swelling of the face or extremities	c. [ ] Epinephrine	[ ] Antihistamine
d.	Gut — Nausea, abdominal cramps, vomiting, diarrhea	d. [ ] Epinephrine	[ ] Antihistamine
e.	Throat + — Tightening of throat, hoarseness, hacking cough	e. [ ] Epinephrine	[ ] Antihistamine
f.	Lung + — Shortness of breath, repetitive coughing, wheezing	f. [ ] Epinephrine	[ ] Antihistamine
g.	Heart + — Weak or thready pulse, low blood pressure, fainting, pale, blueness	g. [ ] Epinephrine	[ ] Antihistamine
h.	Other + _____	h. [ ] Epinephrine	[ ] Antihistamine
i.	If reaction is progressing (several of the above areas affected), give:	i. [ ] Epinephrine	[ ] Antihistamine

(+ *Potentially life-threatening. The severity of symptoms can quickly change.*)

DOSAGE: Numerically state the order in which the medications are to be administered:

_____ **EPINEPHRINE:** inject intramuscularly: (circle one): EpiPen Jr® 0.15mg | EpiPen® 0.3mg | Auvi-Q 0.15mg | Auvi-Q 0.3mg

- A trained delegate may only administer epinephrine, therefore if an antihistamine and epinephrine are ordered, the delegate may skip the antihistamine and administer epinephrine immediately for symptoms.
- A trained delegate **may not** administer a 2nd dose of epinephrine.
- Repeat X _____ in _____ minutes.

_____ **ANTIHISTAMINE:** give _____
medication/dose/route

_____ **OTHER:** give _____
medication/dose/route

SELF-ADMINISTRATION:** (***Under NJ State Law, orders for antihistamines alone cannot be self-administered.*)

[ ] This student has been trained and is **capable of self-administration** of the following medication(s):

[ ] Epinephrine – single dose unit [ ] Epinephrine & antihistamine – single dose units

[ ] This student is **NOT capable of self-administration** of the medications named above.

Physician's Signature: _____ Date _____

Physician's Telephone: _____ Physician's Providers Stamp:

STEP 2: EMERGENCY CALLS

1. **CALL 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. **PARENT:**

Name:		
Cell:	Work:	Home:

PARENT:

Name:		
Cell:	Work:	Home:

IF PARENT/GUARDIAN CANNOT BE REACHED, do not hesitate to medicate or have child transported via rescue squad to nearest emergency medical facility!

STEP 3: PARENT/GUARDIAN CONSENT & RELEASE

BY SIGNING BELOW:

- I verity that my child _____ has a potentially life threatening illness **and has been instructed in self-administration** of the prescribed medication in a life threatening situation.
- **I hereby give my permission for my child to self-administer prescribed medication.** I further acknowledge that the Roxbury Township School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child, if procedures specified by NJ law and Roxbury Township School District policy are followed. I shall indemnify and hold harmless the Roxbury Township School District and its employees or agents against any claims arising out of administration of medication to my child.
- **I hereby give permission for a trained delegate, if available, to administer prescribed epinephrine to my child in the absence of the nurse.**
- **I hereby give consent for the disclosure of the information contained in the Anaphylaxis Action Plan to all staff who may be involved in the implementation of the plan and to other appropriate staff.**

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

ROXBURY TOWNSHIP PUBLIC SCHOOLS

Succasunna, NJ

Medication Policy

Effective June 2020, Roxbury Township Board of Education adopted revised Policy #5330 regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
    a. Name of the student
    b. Diagnosis or type of illness involved
    c. Name of the medication
    d. Dosage
    e. Time of administration
    f. Time when its use will be discontinued
    g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled containe**r. Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at www.roxbury.org/Page/749.

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | Medication Administration Daily Log (to be completed for each medication)

v.20231211

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R Franklin Jefferson Kennedy Nixon

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Parent/Guardian's signature granting permission for administration of medication/sharing of information with appropriate staff members:

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

Name & Dosage of Medication _____ Route _____ Time(s) Given in School _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

Reason for medication _____

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Initial & Signature of Person administering medication Codes^

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

(A) Absent
(O) No Show
(W) Dosage Withheld
(N) No Medication Available
(E) Early Dismissal
(F) Field Trip
(X) No School (e.g. Holiday; Weekend; Snow Day; etc.)

^See reverse side for reporting significant information.

This permission form is effective only for the school year for which it is granted and must be renewed each school year.

Date	Explanation (with Signature)	Date	Explanation (with Signature)

ROXBURY SCHOOL DISTRICT | Permission for Self-Administration of Medication for Potentially Life-Threatening Illness

v.20231211

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Name of Medication _____

Dosage of Medication _____

Guidelines for Administration *(Please be specific)* _____

_____

Possible Side Effects _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

I certify _____ suffers from a potentially life-threatening illness _____
(Student's Name) *(Condition)*

and: ■ is capable of, and has been instructed in, the proper method of self-administration of the above stated medication; ■ is physically fit to attend school and is free of contagious disease; and ■ the medication must be administered during the school day or the student would not be able to attend school.

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

To be completed by the parent/guardian:

I acknowledge that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the school district, the Board, and its employees or agents against any claims arising out of the self-administration of medication by my child.

I give permission for _____ to self-administer _____ as prescribed by his/her physician.
(Student's Name) *(Medication)*

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

This permission form is effective only for the school year for which it is granted and must be renewed each school year.