



**WASHINGTON
TOWNSHIP**
SCHOOL DISTRICT

BRASS CASTLE SCHOOL
16 Castle St.
Washington, NJ 07882
908.689.1188
Jessica L. Garcia, PRINCIPAL

**DISTRICT CENTRAL OFFICE
OLD SCHOOLHOUSE**
One East Front Street
Washington, NJ 07882
908.689.1119
Keith T. Neuhs, SUPERINTENDENT

PORT COLDEN SCHOOL
30 Port Colden Rd.
Washington, NJ 07882
908.689.0681
Michael J. Neu, PRINCIPAL

Dear Parents,

Please review the information and forms provided. **Section I** is the Allergy & Anaphylaxis Action Plan (page 1-2) which must be completed and signed by your child's physician prior to the first day of school. **Section II** is a Parental Authorization section (page 3-4) that requires your signature. These forms will provide us with the recommended treatment, as well as permission to delegate and share information on a need-to-know basis.

If new to the school district, please send in a photo of your child to attach to the Action Plan. A copy of your child's photo will also be placed in a cafeteria folder to assist lunchroom aides and substitutes in identifying your child.

Please bring in Epinephrine auto-injectors (EpiPen, Auvi-Q, Twin-ject, etc) and Benadryl prior to the first day of school, along with the completed Allergy & Anaphylaxis Plan. Submission of these plans as early as possible, prior to the start of school, is appreciated. If your physician orders a second dose of epinephrine, you must supply 2 auto-injectors. Medications brought into school **MUST NOT** expire before the end of the school year. IHCP (Individual Health Care Plans) and Emergency Care Plans (ECPs) are created specific for your child's needs.

A list of students with allergies is faxed to the transportation office, prior to the start of school. Please introduce your child to the bus driver on the first day of school.

Letters will be sent to your child's classroom parents, informing them the classroom is an "Allergy Sensitive Room". Please note, your child's name will not be disclosed to any individual other than a need-to-know district staff member or transportation staff.

Please call with any questions or concerns.

Thank you,

Noreen McGeary, BSN, RN, NJ-CSN
School Nurse
Port Colden School
908-689-0681 ext 2507

Dana Roberts, BSN, RN, NJ-CSN
School Nurse
Brass Castle School
908-689-1188 ext 3607

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ALLERGY & ANAPHYLAXIS ACTION PLAN

MEDICATION FORM FOR LIFE THREATENING ALLERGIC REACTION

This form must be completed and signed by the student's physician/health care provider and signed by parent/guardian.

Student Photo

Student Name _____ DOB _____ Gr _____

SECTION I - TO COMPLETED BY THE PHYSICIAN/HEALTHCARE PROVIDER

Allergen(s) _____

Symptoms in past _____

Epinephrine required in past? ☐ Yes ☐ No

Is this a potentially life-threatening allergic reaction? _____ YES _____ NO

Is this student asthmatic? (higher risk for severe reaction) _____ YES _____ NO

Has allergy testing been completed? _____ YES _____ NO

A. Treatment When the Nurse is Present

Symptoms:

1. Know exposure to allergen **but no symptoms**:
2. Mouth (itching, tingling or swelling of the lips, tongue, mouth)
3. Skin (hives, itchy rash, swelling of the face or extremities)
4. Gut (nausea, abdominal cramps, vomiting, diarrhea)
5. Throat (tightening of throat, hoarseness, hacking cough)
6. Lung (shortness of breath, repetitive coughing, wheezing)
7. Heart (thread pulse, low BP, fainting, pale, cyanosis)
8. If reaction is progressing (several of the above areas affected)
9. Other _____

Give checked medication:

_____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine
 _____ Epinephrine _____ Antihistamine

Dosage:

Epinephrine (Inject intramuscularly): BRAND _____ DOSAGE _____

Epinephrine may be repeated, if necessary, in _____ minutes.

Antihistamine: give (medication, dose, route) _____

Other: give (medication, dose, route) _____

COMPLETE ALL PAGES

B. Treatment by Delegate When the Nurse is NOT Present - NJ PL 2007 c 57 directs that the school nurse shall designate additional employees of the school district who volunteer to administer epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene.

(1 OR 2 MUST BE COMPLETED)

1. **Delegate Order** - For suspected exposure to allergen(s) listed above and showing signs of an allergic reaction, delegates are to immediately administer epinephrine (check one):

☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3mg ☐ Twinject 0.15mg ☐ AuviQ 0.3mg ☐ AuviQ 0.15mg

NOTE: Delegate may only give first dose of Epinephrine then 911 will be called immediately.

2. **This student's order should not be delegated.**

C. Treatment by Student (Self-Administration) - NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction, provided proper procedures are followed.

 *Yes No (Check one) Student may self-administer the medication prescribed (epinephrine and antihistamine)?

*(*If yes, please complete the questions below. In order to have permission to self-administer, all questions in Step IC must be checked "yes.")*

 Yes No Student understands the purpose, proper technique of administration and frequency of use of the medication prescribed above and is capable of self-administration of the medication.

 Yes No Student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used medication.

EMERGENCY CALLS

► Call 911 and state that a student has allergic/anaphylactic reaction and request that paramedics transport the student to the hospital.

► Contact the parent/guardian.

If a student should suffer an anaphylactic reaction and neither the school nurse, nor the delegate is available, the emergency medical system (911) will be activated.

This order is valid from September 1, _____ through August 31, _____
***** All Medication Orders Must Be Renewed Annually*****

Physician/Healthcare Provider's Signature

Date _____

OFFICE STAMP

(END OF PHYSICIAN/HEALTHCARE PROVIDER SECTION)

SECTION II – TO BE COMPLETED BY PARENT/GUARDIAN

A. Parent Authorization (to be completed for all students)

I hereby give permission for my child to receive medication at school as prescribed above by their physician/healthcare provider. I also give permission for the release and exchange of information between the school nurse and my child's physician/healthcare provider concerning any health matters and medications. In addition, I understand that this information will be shared with school staff on a need-to-know basis.

Parent Signature _____ Date _____

B. Parent authorization for the administration of epinephrine by designees/delegates (to be completed for all students for whom the physician/healthcare provider has completed Section 1 B for epinephrine delegates.)

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates/designees trained by the certified school nurse to administer epinephrine in the event the school nurse is not present at the scene. I understand that neither the district nor any of its employees shall be liable for any injury resulting from the administration of epinephrine to a student and I agree to indemnify and hold harmless the district and its agents against any related claims.

Parent Signature _____ Date _____

C. Parent Authorization (for students with physician permission to self-administer medication)

1. I understand that neither district nor any of its employees shall be liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless the district and its agents against any related claims.

Parent Signature _____ Date _____

2. I give permission for my child to self-administer medication as prescribed on this form for the current school year as I consider him/her to be responsible and capable of self-administration of medication. Medication must be kept in its original prescription container. I understand my child is to keep the medication for self-administration with him/her at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre-measured dose of antihistamine, in its original labeled container, is to be kept with the student, along with the epinephrine, at all times.

Parent Signature _____ Date _____

Hospital Preference _____

Physician's Name _____ Phone #: _____

Parent/Guardian _____ Phone#: _____ Relationship: _____

Emergency Contacts 1. _____ Phone#: _____ Relationship: _____

2. _____ Phone#: _____ Relationship: _____

Student's Name: _____ Grade/Teacher: _____

Please review and check your choices for your child:

I ☐ **DO** / ☐ **DO NOT** wish to have my child seated at the nut-aware and/or milk and nut-aware table in the student lunchroom. I understand that, although the tables are washed in-between lunch periods, residue may remain on the table and seats from a previous lunch.

_____ My child may purchase lunch in the cafeteria. *If you wish for your child to purchase lunch, it is strongly advised that you contact food service personnel to review ingredient labels of the food served in the cafeteria to be sure it is safe for your child.*

_____ My child is to eat *only* foods sent from home.

_____ Contact me regarding class parties/event snacks and I will advise you in writing if my child may eat it. I will send in a supply of alternate snacks for my child in the event that the food item is not appropriate for my child.

I understand that information on my child's allergy is shared with staff on a need-to-know basis. Copies of the Emergency Care Plan (ECP) will be placed in the sub folders of the education staff and School Nurse, and a copy given to Transportation Coordinator for the bus drivers.

Parent/Guardian Signature

Date

(END OF PARENT/GUARDIAN SECTION)

For office use only:

Date received from parent: _____

Student has permission to carry medication: YES NO

Medication carried: _____

School Nurse signature: _____

Date ECP sent to Transportation: _____

Date ECP sent to teacher: _____