Wall Township Board of Education

Department of Health Services

Dear Parent/Guardian:

Your child currently has a doctor's order for the administration of epinephrine in the event that he/she has an anaphylactic reaction in school. Previously, the only person who could administer epinephrine to your child was a registered nurse working in the school. Recent changes in the New Jersey State Administrative Code now allow for the use of delegates to administer epinephrine if there is no nurse in the school building and/or during school sponsored activities provided the parent and the student's personal physician both agree this is appropriate. The delegated persons will be trained by the school nurse in the recognition and emergency treatment of anaphylaxis. In addition he/she must be CPR certified. **Completion of the attached documents by you and your child's physician is required for your child to have a delegate in school.** Please return this form with your signature, along with the attached documents, at your earliest convenience. If you have any questions regarding this please contact me at the phone number below.

Thank you for your cooperation.

Sincerely,

School Nurse

Phone # _____

I do/do not (**please circle one**) want my child to have a delegate to administer epinephrine, if necessary, in the school nurse's absence. The attached forms are complete.

Parent
signature_____

This permission must be renewed at the beginning of each school year.

WALL TOWNSHIP PUBLIC SCHOOLS
HEALTH SERVICES

RE: _____
Student's Name

Dear Doctor:

Please review and complete the attached forms that will enable school employees other than the school nurse to administer epinephrine in the event of anaphylaxis. The delegated persons will be trained by the school nurse in the recognition and emergency treatment of anaphylaxis. Additionally, he/she **must** be CPR certified.

The delegate would only be used if the school nurse or substitute school nurse was not available and/or on school sponsored activities.

If you **do not** want a delegate to be used, please sign below. If you agree to the use of a delegate, please complete the attached forms and return them to the school nurse.

Thank you for your cooperation.

_____
School Nurse

_____
Fax #

Refusal of Delegation

I **do not** want the above named student to have a delegate for the administration of epinephrine in school. Only the school nurse may administer epinephrine.

_____
Physician's Stamp

_____
Physician's Signature

Student Photo

WALL TOWNSHIP BOARD OF EDUCATION
18TH AVENUE WALL, NJ 07719
FILE CODE: 5141.21R 9322.

WALL TOWNSHIP PUBLIC SCHOOLS
STUDENTS WITH SPECIAL HEALTH CARE NEEDS

EMERGENCY PLAN

Student: _____ Date: _____
Birth date: _____
Preferred hospital in case of emergency: _____
Physician Name: _____ Phone #: _____

Location of Epinephrine: _____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems	Symptoms
• Mouth	itching & swelling of the lips, tongue or mouth
• Throat*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
• Skin	hives, itchy rash and/or swelling about the face or extremities
• Abdomen	nausea, abdominal cramps, vomiting and/or diarrhea
• Lung*	shortness of breath, repetitive coughing and/or wheezing
• Heart*	"thready" pulse, "passing out"

The severity of symptoms can quickly change.
*All above symptoms can potentially progress to a life-threatening situation!

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
    a. State who you are.
    b. State where you are.
    c. State problem.

EMERGENCY CONTACTS	TRAINED DELEGATES
1. _____ Relation: _____ Phone: _____	1. _____ Room _____
2. _____ Relation: _____ Phone: _____	2. _____ Room _____
3. _____ Relation: _____ Phone: _____	3. _____ Room _____

_____
Signature of Physician

WALL TOWNSHIP PUBLIC SCHOOLS

Release from Physician and Parent for School Nurse to Administer Medication to Student

All medications (whether prescription or over the counter) shall be brought to school by the parent/guardian in the original labeled container and shall be picked up at the end of the period of medication or at the end of the school year. **Prescribed and over the counter medications, including vitamins, all require a written doctor's order.**

Children are not permitted to self-administer any medication in school. (Students needing life saving medication are an exception to this rule, but must have proper documentation from their physician on file in the health room.)

- The Board shall not be responsible for any diagnosis and treatment of student illness.
- The administration of medication to a student during school hours will be permitted only when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine were not made available to him/her during school hours.
- For purposes of this policy, *medication* shall include all medicines **prescribed** by a physician for the particular student, including emergency medication in the event of bee stings, etc., and all over the counter medications.
- Before any medication may be administered to or by any student during school hours, the Board shall require the written request of the parent/guardian who shall give permission for such administration and relieve the Board and its employees of liability for administration of medication.
- **In addition,** the Board requires the written order of the physician (even for over the counter medication) which shall include:
  a. The purpose of the medication;
  b. The dosage;
  c. The time which or the special circumstances under which medication shall be administered;
  d. The length of time for which medications are to be taken. The release must be renewed by the physician and parents annually or when a re-evaluation of the student is indicated;
  e. The possible side effects of the medication.

STUDENTS NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

INSTRUCTIONS REGARDING THE ADMINISTRATION OF MEDICATION: _____

_____

POSSIBLE SIDE EFFECTS OF THE MEDICATION: _____

_____

The school nurse has permission to administer the above medication as prescribed.

DOCTOR'S SIGNATURE: _____

PHYSICIAN'S STAMP: _____

(Form is invalid without physician's stamp)

DATE: _____ PHONE NUMBER: _____

PARENT'S SIGNATURE: _____

DATE: _____ PHONE NUMBER: _____

SCHOOL NURSE'S SIGNATURE: _____ DATE: _____

Written Orders submitted by fax must be **verified by the school nurse.**

WALL TOWNSHIP PUBLIC SCHOOLS
SELF- ADMINISTRATION OF INHALER OR
EPINEPHRINE VIA AUTO SELF- INJECTION

Student: _____ Class: _____

The student named above has a potentially life threatening condition which requires immediate use of an inhaler or epinephrine via auto self- injection. The student has been instructed in the proper use of the inhale or epinephrine via auto self- injection by me or a member of my staff and has successfully demonstrated the use of inhaler or epinephrine via auto self- injection. I feel this student is capable of self-administration of the medication.

DIAGNOSIS FOR WHICH MEDICATION IS GIVEN: _____

MEDICATION AND DOSAGE: _____

INDICATIONS FOR USE: _____

HOW SOON MAY IT BE REPEATED? _____

SIDE EFFECTS: _____

FOLLOW- UP CARE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S STAMP: _____
(Form is invalid without a Physician's stamp)

WAIVER OF LIABILITY

We, parents of _____, in our personal capacities and as the parents and natural guardians of said child request the Wall Township School District permit our child to carry and use an inhaler or epinephrine via auto self- injection while on school property or while off school property at an approved school event. We agree to comply with the regulations of the school district and in consideration of the privilege extended to us and our child, we hereby agree to indemnify and hold harmless the Board of Education of the Wall Township School District and its employees from and against any and all losses, claims, damages or expenses arising from or growing out of the acceptance by the Board of the request recited above.

We also agree to provide an additional inhaler or epinephrine via auto self- injection, identical to the one which the pupil is authorized to carry, which shall be retained by the school nurse in accordance with school policy.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL PHYSICIAN SIGNATURE: _____ DATE: _____

*PERMISSION TO SELF-ADMINISTER MUST BE RENEWED ANNUALLY.

Wall Township Public Schools

History and Documentation of Anaphylactic Reaction

Your child_____, has a medical history of allergies to _____

Your child has an order for Epinephrine and/or Benadryl for an allergic reaction.

_____

Has you child ever had a documented case of anaphylaxis? _____Yes _____No

If your child has had a documented case of anaphylaxis, please answer the following questions:

Event #1

1. What food/insect sting cause the reaction _____
2. Was child taken to the hospital/Name of hospital_____
3. Date of incident_____
4. Medication given to child _____
5. Were you aware of allergy prior to this event_____
6. Was child admitted to the hospital/length of stay_____
7. Any other information you would like to share _____

_____

Event #2

1. What food/insect sting cause the reaction _____
2. Was child taken to the hospital/Name of hospital_____
3. Date of incident _____
4. Medication given to child _____
5. Were you aware of allergy prior to this event_____
6. Was child admitted to the hospital/length of stay_____
7. Any other information you would like to share _____

_____

Parent/Guardian Signature _____Date_____