RAMAPO INDIAN HILLS REGIONAL HIGH SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name_____Birth date_____ Grade_____

The above student is allergic to:_____

Previous episode of anaphylaxis: ▢ Yes ▢No

Epinephrine or Generic: ▢ Self Carry ▢ In the Nurse's office ▢ Exp date:_____

MILD SYMPTOMS

▢ **CONTACT-** with allergen, but no symptoms
▢ **NOSE-** itchy or runny nose, sneezing
▢ **MOUTH**- itchy mouth
▢ **SKIN**- a few hives, mild itch
▢ **GUT**- mild nausea or discomfort
▢ **OTHER-**_____

For **MILD SYMPTOMS** FROM **A SINGLE SYMPTOMS** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person.
3. Watch closely for changes. If symptoms worsen give epinephrine.
4. Delegates cannot administer antihistamine, in the absence of a school nurse, a trained delegate will give epinephrine only and any antihistamine order will be disregarded.

ANTIHISTIAMINE_____Dose_____

SEVERE SYMPTOMS

▢ **CONTACT-** with allergen, but no symptoms
▢ **LUNG-** shortness of breath, sneezing, repetitive cough
▢ **HEART-** pale or bluish skin, faintness, weak pulse, dizziness
▢ **THROAT-** tight or hoarse throat, trouble breathing or swallowing
▢ **MOUTH**- significant swelling of the tongue or lips
▢ **SKIN**- many hives over body, widespread redness
▢ **GUT**- repetitive vomiting severe diarrhea
▢ **OTHER**- feeling something bad is about to happen, anxiety, confusion OR_____

For **SEVERE** symptoms from **ANY** of the following symptoms or **A COMBINATION** of symptoms from different body areas

EPINEPHRINE AUTO-INJECTOR_____Dose_____

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▢ This student has been trained and is capable of self-administration of the following medications(s) named above.
▢ Epinephrine-auto injector ▢ Epinephrine-auto injector & antihistamine
▢ This student is **NOT** capable of self administration of the medicine

Parent/Guardian signature_____Date_____

Physcian/HCP authorization signature_____Date_____

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Parents/guardians

- **It is the responsibility of the parent/guardian to provide a current pre-filled, single dose auto injector mechanism containing epinephrine; prescribed and labeled for your child**
- **The parent/guardian is responsible for replacing the prefilled, single dose auto injector mechanism containing epinephrine when it has expired and /or has been used**
- **Orders must be renewed yearly and provided to the school on or prior to the first day of classes**

Select one-

1. I verify that my child_____has a potenitally life threatening illness and is **unable to self-administer** the prescribed medication in a life threateing situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to the my child. I further acknowledge that the Ramapo/indian Hills School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Ramapo/Indian Hills School District are followed, I shall indemnify and hold harmless the Ramapo/Indian Hills School District and it's employees or agents against any claims arising out of administration of medication to my child.

_____Date_____

Signature of Parent/Guardian

2. I verify 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 permission for my child to self administer** prescribed medication. I further acknowledge that the Rampo/Indian Hills 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 Ramapo/Indian Hills policy are followed, I shall indemnify and hold harmless the Ramapo/Indian Hills School District and it's employees or agents against any claims arising out of self administration of medication by my child.

_____Date_____

Signature of Parent/Guardian