Greenwich Township School District

2022-2023 Food Allergy or Insect Sting Medication Form

Page 1 To be completed by parent/guardian:

Student: _____ **DOB:** _____ **Grade:** _____ **Teacher:** _____

Parent/Guardian: _____ **Parent/Guardian Telephone:** _____

Physician: _____ **Physician Telephone:** _____

Emergency Contact: _____ **Emergency Contact Telephone:** _____

Hospital Preference: _____

Parent/Guardian Authorization

I, hereby, grant permission for my child to receive medication at school as prescribed by my child's physician. I also grant permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medications.

I release the Greenwich Township Board of Education, its officers, employees, agents, and representatives from any and all claims, liability or damages related to or resulting from the administration of medication to my child. I indemnify and hold harmless the Greenwich Township Board of Education, its officers, employees, agents, and representatives against any and all claims arising out of the self-administration of medication.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Authorization for the Self-Administration of Epinephrine while on Field Trips and Before/After School Programs

I grant this written authorization for my child to self-administer his/her Epipen, Epipen Jr., or Twinject (circle one) for the allergy to _____ while on field trips and before/after school programs.

I release the Greenwich Township Board of Education, its officers, employees, agents, and representatives from any and all claims, liability or damages related to or resulting from the administration of medication to my child. I indemnify and hold harmless the Greenwich Township Board of Education, its officers, employees, agents, and representatives against any and all claims arising out of the self-administration of medication.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Request for the Delegation of Emergency Administration of Epinephrine

My child has a history of a severe allergy to _____ and requires the administration of epinephrine when he/she has been exposed to the substance(s) above. My child is unable to self-administer epinephrine and ,so, I request the school nurse delegate and instruct another member(s) of the district staff to administer the epinephrine via a pre-filled, single dose auto-injector mechanism when the nurse is unavailable.

I understand that my physician must provide written authorization (located on page 3 of this packet) before delegation can occur. I also understand that it is the responsibility of the parent to provide the school with a current, pre-filled, single dose auto-injector mechanism containing epinephrine. I understand that this request must be renewed each academic year.

Provided the procedures outlined in N.J.S.A. 18A:40-12.5 and the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, I release the Greenwich Township Board of Education, its officers, employees, agents, and representatives from any and all claims, liability or damages related to or resulting from the administration of medication to my child. I indemnify and hold harmless the Greenwich Township Board of Education, its officers, employees, agents, and representatives against any and all claims arising out of the self-administration of medication. The administration of Benadryl cannot be delegated.

Parent/Guardian Signature: _____ **Date:** _____

Greenwich School offers a **"nut free table"** in the cafeteria to students that may be allergic to peanuts and/or any type of nuts or nut products. Please check one below:

☐ I **would like** my child to sit at the **nut free table** in the **cafeteria**.

☐ I **do not want** my child to sit at the **nut free table** in the **cafeteria**.

Pages 2 and 3 To be completed by physician

This child has an allergy to: _____

This child is allergic to the following medications: _____

Has this child had a reaction in the past? ☐ Yes ☐ No

Has allergy testing been recommended? ☐ Yes ☐ No

Has allergy testing been completed? ☐ Yes ☐ No

Specific physician recommendations: _____

If the following occurs, administer the checked medication(s):		
	Antihistamine	**Epinephrine**
Contact with allergen, symptomatic or asymptomatic.		
Ingestion of allergen, symptomatic or asymptomatic.		
Skin - hives, itchy rash, extremity swelling.		
Mouth - itching, tingling, burning or swelling of lips, tongue or mouth.		
Gut - abdominal cramps, nausea, vomiting, diarrhea.		
Throat - throat-tightening, hoarseness, hacking cough.		
Lung - repetitive cough, wheezing, shortness of breath.		
Heart - thready pulse, low blood pressure, fainting, pale or bluish skin.		
Other symptoms: _____		

Medication Dosage Emergency Plan

Please check one administration order:

- ☐ Administer Antihistamine first, observe for thirty minutes, of symptoms progress, administer Epipen.
- ☐ Administer Epipen and Antihistamine at the same time.
- ☐ Administer Epipen only.
- ☐ Administer Antihistamine only.

1. Antihistamine

Medication	**Dose**	**Route**	**Time**	**# of Days**	**Side Effects**

2. Epinephrine

- ☐ Epinephrine 0.3 mg
- ☐ Epinephrine Jr. 0.15 mg
- ☐ Auvi Q 0.3 mg
- ☐ Auvi Q 0.15 mg

Route	**Time**	**# of Days**	**Side Effects**

If Epinephrine is administered:

Call 9-1-1, parent/guardian and principal
Continue to monitor airway, breathing and circulation
Perform CPR or rescue breathing as needed
Place oxygen mask on patient @ 15 l/min
Monitor vital signs
Elevate legs if blood pressure is low

Physician Authorization for Self-Administration of Medication While on Field Trips and During Before/After School Programs.

This child has a potentially life-threatening illness and is capable of and has been instructed in the proper way to self-administer the Epipen, Epipen Jr. (circle one) while on field trips and during before/after school programs.

Physician's Signature: _____ **Date:** _____

Physician Authorization for the Delegation of Emergency Administration of Epinephrine.

This child has a documented history of anaphylaxis. I certify that this student does not have the capacity to self-administer Epinephrine and, so, request the school nurse to delegate to another school employee(s), the emergency administration of Epinephrine via an auto-injector to this child when the school nurse is unavailable. The symptoms to administer epinephrine are detailed on page 2 of this packet.

Please note: The administration of Benadryl cannot be delegated - ONLY Epinephrine.

Physician's Signature: _____ **Date:** _____