HASBROUCK HEIGHTS PUBLIC SCHOOL
SCHOOL HEALTH SERVICES

EPI-PEN PACK

TO BE COMPLETED BY THE PARENT & DOCTOR

Physician's Order for Medication (2)

Epi-Pen & Benadryl ***(if applicable)***

Food Allergy Action Plan

TO BE COMPLETED BY THE PARENTS

Epi-Pen Forms (3)

Lincoln School
Kimberly Kane, RN
(201) 393-8184 office
(201) 393-0365 fax

HS/MS
Mary Neumann, RN
(201) 393-8160 office
(201) 393-8948 fax

Euclid School
Jolanta Czajkowski, RN
(201) 393-8178 office
(201) 288-0753

PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:

PHYSICIAN'S NAME
ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:

PHYSICIAN'S NAME
ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____**D.O.B:**_____**Teacher:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but *no symptoms*:		Epinephrine	Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
Throat†	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Lung†	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other†	_____	Epinephrine	Antihistamine
If reaction is progressing (several of the above areas affected), give:		Epinephrine	Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____
4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____

Exhibit File Code 5141.21

HASBROUCK HEIGHTS BOARD OF EDUCATION
379 Boulevard Hasbrouck Heights,
New Jersey 07604

PARENTS' AUTHORIZATION FOR ADMINISTRATION OF EPI-PEN TO CHILD

I/We, the parent's/guardian'(s) of _____ , hereby authorize the Hasbrouck Heights School District and its employees and agents to administer epinephrine via Epi-Pen to our child, _____ , in an emergency.

I/We acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the administration of the Epi-Pen and I/We agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the administration of the Epi-Pen to _____.

I/We acknowledge that this authorization is effective for the entire school year of _____.

_____ _____
Parent's / Guardian's Printed Name Telephone Number

_____ _____
Parent's / Guardian's Signature Date

_____
Parent's / Guardian's Signature

(PARENTS)

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Hasbrouck Heights, New Jersey

PARENTS PERMISSION

EPI-PEN DELEGATE

We (I) the undersigned, who are the parents/guardians of _____ born on _____ , request that a delegate be permitted to administer the following medication: _____ to our child The medication has been prescribed by our physician:

Doctor's Name _____ Telephone #_____

Address_____

We will notify the school immediately if the health status of_____ changes, we change physicians, or there is a change or cancellation of the medication.

We (I) understand that according to the procedures in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine", the district shall incur no liability as a result of any injury arising from the administration of medication by the delegate and that the parent/guardians shall indemnify and hold harmless the district and its' employees or agents against any claims arising out of the delegate's administration of this medication.

Parent's Name_____ Date_____

Parent's Signature _____ Telephone #_____

Address_____

(PARENTS)

HASBROUCK HEIGHTS PUBLIC SCHOOLS
379 Boulevard Hasbrouck Heights, New Jersey 07604

Dr. Matthew H
Superintendent of Schools

Tel: (201) 393-8145
Fax: (201)288-0289

Dear Parent(s)/Guardians:

You have requested that the Hasbrouck Heights School District, its employees and agents, in the case of emergency, administer epinephrine via Epi-Pen to your child,

The school district shall comply with your request pending receipt of written authorization from you allowing the Hasbrouck Heights School District, and its employees and agents, to administer epinephrine via Epi-Pen to your child, _____ We also require written orders from your child's primary care physician or nurse practitioner, _____ , that your child requires administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.

In addition, it is your responsibility to provide a current, pre-filled, single dose autoinjector mechanism containing epinephrine when it has expired.

Please be advised that the school district and its employees or agents shall have no liability as a result of any injury arising from the administration of the Epi-Pen to your child, _____ , and that you must agree, by completing the en closed authorization form, to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the administration of the Epi-Pen to _____ .

_____ _____

Parent's Signature Date