CITY OF ELIZABETH, NEW JERSEY
DEPARTMENT OF HEALTH and HUMAN SERVICES
PUBLIC HEALTH NURSING SERVICES
50 Winfield Scott Plaza, Elizabeth, NJ 07201-2462
Phone: (908) 820-4250
Fax: (908) 820-4252

KRISHNA H. GARLIC
Director

J. CHRISTIAN BOLLWAGE
Mayor

Date:_____

Dear Parent/Guardian:

Re: Epi-Pen Administration in School

Please have your physician complete and sign the enclosed forms for administration of the epi-pen auto injector, in case of a severe allergic reaction. Two epi-pens would be required. One is for the student to carry at all times, if appropriate, and another is to be kept in school.

Return the completed form to The Patrick School.

Thank you for your cooperation in this matter.

Sincerely,

_____
Public Health Nurse/The Patrick School

EMERGENCY HEALTH CARE PLAN

ALLERGY TO:_____ **Place Child's Picture Here**

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

Asthmatic Yes*_____ No_____ *High risk for severe reaction

* SIGNS OF AN ALLERGIC REACTION *

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
• GUT	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.

* ACTION FOR MINOR REACTION *

If only symptoms(s) are:_____ give_____
medication/dose/route

Then call:

1. Mother_____, Father_____ or emergency contacts.
2. Dr._____ at_____.

If condition does not improve within 10 minutes, follow steps 1-3 below.

* ACTION FOR MAJOR REACTION *

If ingestion is suspected and/or symptom(s) are:_____
Give_____ **IMMEDIATELY**
medication/dose/route

Then call:

1. Rescue Squad (ask for advanced life support)
2. Mother_____, Father_____ or emergency contacts.
3. Dr._____ at_____.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____ _____ _____
Parent's Signature Date Doctor's Signature Date

AUTHORIZATION TO ADMINISTER EPINEPHRINE

Name of Student: _____ Grade: _____

(To Be Completed by Physician or Advanced Practice Nurse)

The Student named above requires administration of epinephrine for anaphylaxis, and does not have the capability to self-administer the medication.

Dosage: _____

Special Instructions: _____

_____

Description of Emergency Situation: _____

Possible Side Effects: _____

_____ _____

(Date) (Signature of Physician or Advanced Practice Nurse)

Address: _____

_____

Phone: _____

PARENT/GUARDIAN AUTHORIZATION AND ACKNOWLEDGEMENT

I/We hereby authorize the School to administer epinephrine via epi-pen to the student named above, in accordance with New Jersey law and the School policy stated below, as stated in the orders of the physician/advanced practice nurse above. This authorization includes the school nurse or, in the absence of the School nurse, another School employee designated and trained by the School nurse in accordance with New Jersey law.

I/We acknowledge receipt of written notice from the School that, provided the procedures set forth in New Jersey law and School policy are followed, the school and its employees or agents shall have no liability as a result of any injury arising from administration of the epi-pen to the Student. I/We understand and agree that the School and its employees or agents shall have no liability as stated in the written notice. I/We further agree to indemnify and hold harmless the School and its employees or agents against any claims arising out of administration of the epi-pen to the Student.

I/We understand this authorization and these agreements are effective for the duration of the current school year.

_____ Date: _____

(SIGNATURE OF PARENT or GUARDIAN)

_____ Date: _____

Signature of Principal

AUTHORIZATION TO SELF-ADMINISTER MEDICATION IN SCHOOL

(To Be Kept Confidential Upon Completion)

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS/ILLNESS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

SPECIAL DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

I certify that the above information regarding this Student is correct and that administration of the medication to this Student is necessary. The Student has received appropriate instruction to self-administer the medication.

_____ _____

(Signature of Prescribing Physician) (Date)

_____ _____

(Address) (Phone)

I/We understand and agree that the School, the School Nurse, and the School Principal shall not be liable for any injury to the Student resulting from the administration of the medication as authorized by my signature below.

_____

(Signature of Parent/Guardian) (Date)

_____

(Signature of Principal) (Date)

AMENDED: Sept. 2003

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

(To Be Kept Confidential Upon Completion)

NAME OF STUDENT: _____ GRADE _____

DIAGNOSIS/ ILLNESS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

SPECIAL DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

I certify that the above information regarding this Student is correct and that administration of the medication to this Student is necessary.

_____ _____

(Signature of Prescribing Physician) (Date)

_____ _____

(Address) (Phone)

I/We authorize the School Nurse, or in his/her absence, the Parent to administer the above medication as indicated. I/We understand and agree that the School, the School Nurse, and the School Principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

_____

(Signature of Parent/Guardian) (Date)

_____

(Signature of Principal) (Date)

Amended: Sept. 2007

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT _____ DATE _____

DATE OF BIRTH _____ GRADE _____

As Parent/Guardian of the above named student, I here by authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among appropriate professional staff involved in the care of the above student. This consent is valid for the _____ school year and is intended to allow the staff to better serve my child.

_____

Signature of Parent/Guardian