## SOUTH BRUNSWICK BOARD OF EDUCATION

	Emergency Health Care	Plan and Medication Order	rs for Life Inreatening	g Allergies
	Jame:			
School: _		Grade:	Unit/Teacher:	
Allergy to	0:			Asthma: Yes / No
	STEP 1	1: TREATMENT – to be complet	ted by Physician	
Sy	emptoms:		Give Checked M	
If	exposure to an allergen occurs, but no symptoms		(to be determined <b>Epinephrin</b>	7.1
•	Mouth Itching, tingling, or swelling of lips, to	ngue, mouth	☐ Epinephrir	ne
•	Skin Hives, itchy rash, swelling of the face	or extremities	☐ Epinephrir	ne
•	Gut Nausea, abdominal cramps, vomiting,	diarrhea	☐ Epinephrin	ne
•	Throat* Tightening of throat, hoarseness, hacki	ng cough	☐ Epinephrii	ne
•	Lungs* Shortness of breath, repetitive coughin	g, wheezing	☐ Epinephrin	ne
•	Heart* Weak or thready pulse, low blood pres	sure, fainting, pale, blueness	☐ Epinephrii	ne 🗆 Antihistamine
•	Other*		☐ Epinephrin	ne 🗆 Antihistamine
•	If reaction is progressing (several of the above are	as affected), give:	☐ Epinephrin	ne 🗆 Antihistamine
DOG L CT	•	fe-threatening. The severity of sympton	ms can quickly change.	
DOSAGE Eninanha	<u>s:</u> cine – prefilled auto-inject intramuscularly (circle one	a). Ayyri O O 3 mg /Ayyri O O	15 on Eninon 0.2 ma	/ Eni non In 0.15 mg
	mine - give (medication/dose):  Benadryl	_	or <u>Epi-pen 0.5 mg</u>	/ Epi-pen 31. 0.13 mg
111111111111111111111111111111111111111	give (medication dose).	5		
1. <b>Call 9</b> 2	STEP 2: EMI 11 for Rescue Squad and state that an allergic reaction	ERGENCY CALLS – to be comple in has been treated	eted by Parent/Guardian	
2. Call:	Mother: Home:	Work:	Cell:	
	Father: Home:	Work:	Cell:	
Emerg	ency Contacts: First: Name:	Relationship:	Number:	
	Second: Name:	-		
. DI .		_		
3 Physic		Phone		
4. Preferr	red Hospital	Phone	2:	
	and and agree that the student requires the administrat and is capable of self-administration and should carry		nadryl in conjunction with epine	ephrine, when exposed to a specific
	and that the school nurse, when available, is responsible aff member to administer pre-filled single dose auto-	ele for emergency care to the student. In	rgency Health Care Plan. Yes	
I underst	and that I assume full responsibility to ensure tha	CARRYING MEDICATION to my child is carrying epinephrine on		
Parent Sig	<u> </u>			
- 18		FORE AND AFTER SCHOOL F	DDACD AM	
Γhis Eme	rgency Health Care Plan and Medication Order may			/ Not applicable .
of a pre-fi	acknowledge that the South Brunswick Board of Educ tilled, single dose auto-injector mechanism containing by claims arising out of the administration of a pre-fil	epinephrine to the student, and agree to	indemnify and hold harmless tl	
Parent/G	uardian Signature:			Date:
School Ni	urse's Signature:			Date:
rnysician	n's Signature <u>and Stamp</u> :	D:	ate:	