

Saint Dominic School 250 Old Squan Road • Brick, New Jersey 08724 -3284

Web www.stdomschool.org
 Telephone 732/840-1412
 Fax 732/840-6457

**EMERGENCY HEALTH CARE PLAN
 FOR ALLERGIC REACTIONS**

Student Name _____ D.O.B. _____

TO BE COMPLETED BY PHYSICIAN/ADVANCED PRACTICE NURSE

Allergy To _____

Asthmatic
 Yes ___ No ___ * Higher risk for severe reaction

- Has student received epinephrine for anaphylaxis (date)
 Yes ___ No ___
- Has the student been tested?
 Yes ___ No ___
- Has student undergone insect sting desensitization?
 Yes ___ No ___
- Is student able to participate fully in all school athletic programs?
 Yes ___ No ___

Symptoms :	Give Checked Medication	
• If a food allergen has been ingested, but no symptoms:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Throat Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Lung Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Heart Weak or thready pulse, low BP, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Other	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

All above symptoms can potentially progress to a life-threatening situation!

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen /Twinject 0.3mg or EpiPen JR/ Twinject 0.15mg

Antihistamine: (given concomitant/Epinephrine)

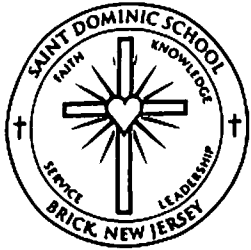
Physician's signature & Stamp _____

Emergency Contacts

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

3. Name _____ Relationship _____ Phone _____



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SCHOOL HEALTH SERVICES

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ALLERGY INFORMATION FORM

Parent/Guardian: Please complete this form and return it to the School Health Room.

Child's Name _____ Grade _____

School _____ ; _____ Date _____

TYPE OF ALLERGY

Check the box next to any allergy your child has experienced and list name/s as requested:

Medication student is allergic to: _____ Name of specific food: _____

Environmental allergens Insect dust, mites, mold, pets, etc. _____

Insect bites/stings _____

SYMPTOMS OF ALLERGY

Check the line next to any symptoms your child has experienced:

___ Hives or giant hives

___ Shock

___ Swelling of _____

___ Fainting - dizziness

___ Difficulty in breathing - wheezing

___ Other (Describe) _

___ Difficulty swallowing

1. Has your child seen a doctor for any of the allergies indicated above? Yes No

2. Has your child ever been hospitalized for any allergic event? Yes No
Describe _____

3. Is medication required immediately after exposure to any allergy producing substance?
Yes No

If Yes, name of medication _____

(Please note: we must have both the *medication* and the signed *Medication/Treatment Authorization Form* on file in order to administer the medication.)

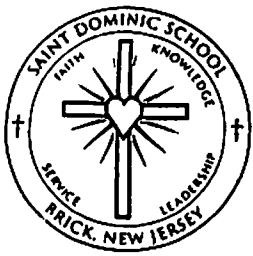
4. If no medication is necessary, how should the school treat the allergic event?
Careful observation Yes No Call parent/guardian Yes No

If dietary changes are medically necessary, a Doctor's order with diagnosis is required.

COMMENTS: _____

Parent/Guardian's Name _____ Phone# _____

Parent/Guardian's Signature _____ Date _____



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Administration of Epinephrine

Student _____

DOB _____

Teacher _____

Grade _____

As parent/guardian of _____ I request the administration of epinephrine via a pre-filled single dose auto-injector mechanism.

Attached are the physician's orders requiring the administration of the epinephrine to my child who does not have the capability for self administration. I understand that the school shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child. I shall indemnify and hold harmless the school and its employees or agents against any claims arising out of administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child.

I will provide a current epinephrine via a pre-filled single dose auto-injector and will be responsible for replacing it when it has expired.

This permission is valid for the _____ school year only.

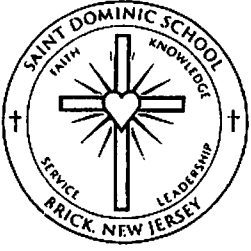
Parent/guardian signature

Date

Parent/guardian name

Cecil A. Bannmann
School Principal

Eileen Culley
School Nurse



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Consent for Delegate Administration

Student _____

DOB _____

Teacher _____

Grade _____

As parent/guardian of _____ I consent to the administration of epinephrine by school delegates via a pre filled single dose auto-injector mechanism.

I acknowledge and understand that the school shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child. I shall indemnify and hold harmless the school and its employees or agents against any claims arising out of administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child.

This permission is valid for the _____ school year only.

Parent/guardian signature

Parent/guardian name

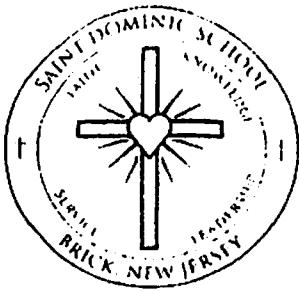
Date

Carol A. Barnman

School principal

Lileen Cutler

School Nurse



Saint Dominic School 250 Old Squan Road • Brick, New Jersey 08724

Web: www.stdomsch.org

Telephone 732/840-1234

Fax 732/840-1234

Parent Release and Indemnification

Student: _____

DOB: _____

Grade/Homeroom: _____

This release is given by the parents/guardians on behalf of their minor child to Saint Dominic School to administer epinephrine medication through a pre-filled auto injection when required by the school nurse or delegate trained by the school nurse.

The parents/guardians are responsible for attaching the physician's orders requiring the administration of the epinephrine to this release, and for replacing the pre-filled auto injector when it has expired.

The parents/guardians agree to provide the school with a number of pre-filled auto injections to be used as needed and understand that if the school nurse is not available, then a trained designee will administer the epinephrine in a pre-filled auto injection.

The parents/guardians understand that the school, its employees, agents will have no liability as a result to any injury arising from the administration or failure to administer epinephrine to the student.

The parents/guardians will indemnify and hold harmless Saint Dominic School, Saint Dominic Parish, employees, and agents from and against claims arising out of the administration or failure to administer epinephrine in a pre-filled auto injection to a student.

This release is valid for the _____ school year only.

Signature of Parent/Guardian

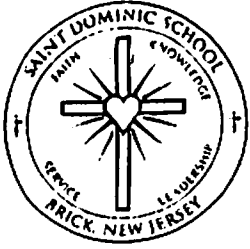
Date

Carol A. Bannerman

Principal

Debra Culley, RN

School Nurses



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AUTHORIZATION FOR RELEASE OF INFORMATION ON NEED TO KNOW BASIS

St Dominic School strives to protect the well-being of our students, especially those with special health needs. This includes assisting teachers, students and administrators to adapt to a student's health problems.

Because of this commitment, it is important that certain confidential information about the student's health problem be shared by parents or guardians. This information will be used to plan for the care and management of the student. It will be shared with those members of the professional staff who have direct responsibility for the student when in school or participating in school activities.

Please complete the release below:

I hereby authorize an exchange of information to occur between the school nurse, my child's physician and those members of the professional staff who have direct responsibility for the student when in school or participating in school activities.

Student's name: _____

Date of Birth: _____

Address: _____

Phone: _____

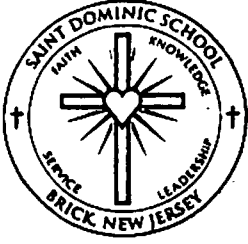
This authorization is effective for one calendar year.

Parent/Guardian Signature

Date

Carl D. Bannmann
School Principal's Signature

Aileen Culley
School Nurse's Signature



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Dear Parent/Guardian,

Your child, _____, in Grade ____ has been diagnosed as allergic to peanuts, nuts and/or products containing these ingredients. Although some children are only mildly allergic and require simple precautions, other children have more serious, life-threatening allergies that necessitate more stringent precautions.

St. Dominic School is asking all parents to cooperate in not sending any peanut or nut containing products into the classrooms for snacks or birthday treats. However, when the children are in the cafeteria, there is a much greater possibility that students could have peanut butter sandwiches or other meals or snacks containing nut products.

In an effort to keep any children with allergies from having an allergic reaction in the cafeteria, St. Dominic School is designating a separate table for students with allergies.

Please sign the form below with your preference for your child's seating in the cafeteria and return the form to **the main office immediately**. Thank you for your cooperation in keeping your child safe and healthy!

Sincerely,

Carol L. Bathmann
Principal

Eileen Culley
School Nurse

____ My child, _____, has allergies and I would appreciate designated seating at a separate table in the cafeteria.

____ I do not wish my child, _____, to be seated at a designated table for students with allergies. My child will be sitting with the rest of his/her class.

Parent's Signature

Date

Child's Grade