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:		□ 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 BP, fainting, pale, blueness	□ Epinephrine •	□ Antihistamine
• Other		□ Epinephrine	□ Antihistamine
• If reaction is progressing (several of the above areas affected), give:		□ Epinephrine	□ 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
__ Swelling of_____
__ Difficulty in breathing - wheezing
__ Difficulty swallowing
__ Shock
__ Fainting - dizziness
__ Other (Describe) _
_____

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

Carol A. Bittmann
School Principal

Ellen Culley
School Nurse

Academic Excellence • Catholic Values

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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 L Barnmaster Eileen Cutley
School principal School Nurse

Saint Dominic School 250 Old Squan Road • Brick, New Jersey 08724
Web: www.stdomsch
Telephone 732/84
Fax 732/84

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 L Entremonte
Principal

Eileen 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 Brith: _____

Address: _____

Phone: _____

This authorization is effective for one calendar year.

_____ _____
Parent/Guardian Signature Date

Carol A. Bahmann
School Principal's Signature

Eileen 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