SAINT DOMINIC SCHOOL

250 Old Squan Road † Brick, New Jersey 08724
Tel: 732.840.1412 † Fax: 732.840.6457 † www.stdomschool.org

NATIONAL BLUE RIBBON
SCHOOL OF EXCELLENCE

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 the student undergone insect sting desensitization?
Yes _____ No _____
Is the student able to participate fully in all school athletic programs?
Yes _____ No _____

Symptoms:	Give Checked Medication	
*If food allergy 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 the above symptoms can potentially progress to a life-threatening situation!

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

Antihistamine: (given concomitent/Epinephrine)

Physician's signature/stamp: _____

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Emergency Contacts

1. **Name** _____ **Relationship** _____ **Phone** _____
2. **Name** _____ **Relationship** _____ **Phone** _____
3. **Name** _____ **Relationship** _____ **Phone** _____
4. **Name** _____ **Relationship** _____ **Phone** _____

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SCHOOL HEALTH SERVICES
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
____ 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
3. Is this medication requirement 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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Consent for Delegate Administration

Student _____ D.O.B. _____

Teacher _____ Grade _____

As parent/guardian of _____ I request that the administration of epineephrine 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 Date Parent/Guardian name

Elizabeth Sonkovich
School Principal

Kristin Halldorson
School Nurse

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Administration of Epinephrine

Student _____ D.O.B. _____

Teacher _____ Grade _____

As parent/guardian of _____ I request that the administration of epineephrine 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-fille, 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

Elizabeth Jonkovich
School Principal

Kristin Halldorson
School Nurse

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Parent Release and Indemnification

Student: _____ D.O.B _____

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, and agents will have no liability as a result of 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

Elizabeth Tonkovich
Principal

Kristin Halldorson
School Nurse

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AUTHORIZATION FOR RELEASE OF INFORMATION ON NEED TO KNOW BASIS

Saint 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

Elizabeth Sonkovich
School Principal's Signature

Kristin Halldorson
School Nurse's Signature