butler public schools

SPECIAL SERVICES
High School Annex Building
Butler, New Jersey 07405
TELEPHONE: 492-207

Date:

Dear Parent,

You have indicated that your child _____ in Grade _____ has a history of an allergic reaction to:

_____

In order to provide emergency care in the event of a life-threatening allergic reaction during the school day and in compliance with N.J. State guidelines and protocols, (NJSA 18A:40-12.5), it is necessary for you to submit pertinent information and the appropriate physician orders. In this way, an individualized health care/emergency plan will be developed for your child.

In addition, if your child is determined to have a life threatening allergy, it is recommended that an ID bracelet be worn at all times.

Please complete and return the enclosed form as soon as possible. If you have any questions, contact the nurse at your child's school.

_____
School Nurse

_____
School Phone

Enclosure

Butler SCHOOL DISTRICT
HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name_____Grade/Teacher/HmRm _____

The above student is allergic to: _____

Asthmatic ☐ Yes ☐ No

MEDICATIONS

PLEASE NOTE: The School Nurse by law may administer any medication with physician's orders and parental consent, but trained non-medical designees, who may give emergency treatment in the School Nurse's absence, are NOT permitted by law to administer any medications other than epinephrine via auto-injector mechanism.

EPINEPHRINE: ☐ EpiPen ☐ EpiPen Jr. ☐Other _____

School Nurse or designee: Give epinephrine for the following checked symptoms:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
☐ Other _____

After giving epinephrine, call 911, parent, and healthcare provider.

ANTIHISTAMINE: Medication _____ Dose _____

School Nurse only: Give antihistamine for the following checked symptoms:

☐ Contact with allergen, but no symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
☐ Gut – abdominal cramps, nausea, vomiting, diarrhea
☐ Lungs – repetitive cough, wheezing, shortness of breath
☐ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
☐ Other _____

OTHER INSTRUCTIONS _____

☐ This student has been trained and is authorized to self-administer the following medication(s) named above. ☐ epinephrine – single dose unit ☐ antihistamine – single dose unit

☐ This student is not authorized to self-administer the medication(s) named above.

Healthcare Provider's signature _____Healthcare Provider's phone # _____

Date_____ Healthcare Provider's Stamp _____

MSD/PM/revised 11/25/2008

AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Date: _____

To be completed by Parent/Guardian:

I/We hereby authorize the Butler Board of Education to allow my/our child _____ to self-administer the medication as described on the previous page. I/We acknowledge that the Butler Board of Education and it agents and employees will incur no liability as a result of any injury arising from the self-administration of medication requested herein. We hereby agree to indemnify and hold harmless the Butler Board of Education, the Butler School District, its agents and employees against any claims arising out of the self-administration of medication requested herein.

We will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. We understand that permission for self-medication is effective only for the school year for which it is granted, and that such permission may be renewed for each subsequent year only upon the submission of a completed request form each year.

_____ Mother

_____ Father

_____ Guardian

_____ Guardian

_____ Pupil (If 18 or older)