GLASSBORO PUBLIC SCHOOLS
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name_____ Birth date_____ Grade/teacher _____

The above student is allergic to: _____

Previous episode of anaphylaxis ☐ Yes ☐ No

1. MEDICATIONS

ANTIHISTAMINE: Name _____ Dose _____

EPINEPHRINE: ☐ EpiPen ☐ EpiPen Jr. ☐ Other _____

2. Administer antihistamine and(or)epinephrine for checked symptoms (to be determined by physician authorizing treatment)

Symptom	Epinephrine	Antihistamine
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 _____	☐	☐

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3. CHOOSE ONE ADMINISTRATION ORDER:

Give Antihistamine only ☐ Give epinephrine only ☐ *Delegate may be assigned
Give Antihistamine & Epinephrine at same time ☐ *Delegate may be assigned
Give Antihistamine first, observe for further symptoms and give epinephrine PRN ☐
***Please note- in the absence of a school nurse, a trained delegate, if assisgned, will give epinephrine and any antihistamine order will be disregarded**

4. SELF ADMINISTRATION AUTHORIZATION

☐ This student has been trained and is capable of self-administration of the epinephrine auto-injector mechanism.

☐ This student is not capable of self-administration of epinephrine auto-injector mechanism.

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Physician's signature _____

Phone number _____

Date_____ Office Stamp _____

GLASSBORO PUBLIC SCHOOLS
Parent Authorization Form

FILL OUT ONE SECTION ONLY

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and Epinephrine must be brought to school by an adult and be provided in the original container.

MY CHILD HAS PERMISSION TO SELF-ADMINISTER (must also be authorized by physician)

I verify that my child _____ has a potentially life threatening illness and **has been instructed in self- administration** of epinephrine via an auto-injector mechanism in a life threatening situation. **I hereby give permission for my child to self administer** epinephrine via an auto-injector mechanism. I further acknowledge that the Glassboro School District shall incur no liability as a result of any injury arising from the self-administration of epinephrine via an auto-injector mechanism by my child. I shall indemnify and hold harmless the Glassboro School District and its employees or agents against any claims arising out of self administration of this medication by my child.

Parent Name (print) _____

Parent Signature _____ Date _____

OR

MY CHILD DOES NOT HAVE PERMISSION TO SELF-ADMINISTER

I verify that my child _____ has a potentially life threatening illness and is **unable to self-administer** the prescribed medication in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child.

I understand that under NJ state law, a trained delegate may be assigned to administer epinephrine to my child in the absence of a school nurse, however antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate

I further acknowledge that the Glassboro School District shall incur no liability as a result of any injury arising from administration of the medication to my child. I shall indemnify and hold harmless the Glassboro School District and its employees or agents against any claims arising out of administration of medication to my child.

Parent Name (print) _____

Parent Signature _____ Date _____