BERGENFIELD BOARD OF EDUCATION
Authorization to Administer Epinephrine

This Authorization is Effective for the _____ School Year Only

Please be advised that the Bergenfield School District and its employees or agents shall have no liability as a result of any injury arising from the administration of epinephrine via a pre-filled auto-injector mechanism.

To be filled out by Parent/Guardian

I authorize the school nurse and /or trained delegate(s) _____ _____to administer epinephrine via a pre filled auto-injector mechanism to my child_____ for anaphylaxis. **I understand and acknowledge that the Bergenfield School District and its employees and agents, including the school nurse and any delegates, shall incur no liability as a result of any injury arising from the administration of epinephrine to my child; and agree to indemnify and hold harmless the Bergenfield Board of Education, the Bergenfield School district, and its employees and agents, including the school nurse and delegates, against any claims arising from the administration of the epinephrine to my child.**

I have received, acknowledge and agree to the provisions of Bergenfield Board of Education Policy No. 5330. My signature indicates consent and agreement with the above statement. This authorization form must be renewed annually.

Signature _____ Date _____

To be filled out by Prescribing Health Care Provider

Name of Child_____ Diagnosis _____
Name of Medication _____
Dosage _____
Frequency and Directions _____
_____
Purpose of Drug/Procedure _____
_____

I certify that the above-name student requires the administration of epinephrine(EPi Pen) for anaphylaxis and that the child/parent/guardian has been instructed in, and understands, the proper method of administration.

_____ _____
(Signature of Health Care Provider) Date

_____ _____
(Health Care Provider's Stamp) Telephone number

HEALTH SERVICES DEPARTMENT
BERGENFIELD PUBLIC SCHOOLS

EMERGENCY HEALTH CARE PLAN FOR SIGNIFICANT ALLERGIC REACTIONS
SCHOOL YEAR 2____ - 2____

Student Name _____ Date of birth _____ Grade/HR _____

Significant allergy to _____

Date of first reaction _____ Date of most recent reaction _____

As displayed by _____

Other medical history _____

Asthmatic: Yes __ No __ Location of Epi Pen(s) _____

PLEASE CIRCLE ALL SYMPTOMS YOUR CHILD HAS EXPERIENCED AS A RESULT OF AN ALLERGIC REACTION

Mouth	**Itching and swelling of lips, tongue or mouth**
Throat	**Itching and/or sense of tightness in the throat; hoarseness; cough**
Skin	**Hives; itchy rash and/or swelling around the face, arms or legs**
Abdomen	**Nausea, abdominal cramps, vomiting, diarrhea**
Lung	**Shortness of breath, wheezing, coughing**
Heart	**Rapid, weak pulse; passing out**
Other	
Other	

ACTION: If exposure to the allergen is suspected and signs and symptoms are noted:

1. Call nurse at _____

2. If nurse is available, she will respond and go directly to the location. **NEVER** leave student alone.

3. Nurse will assess and follow physician's orders.

4. If nurse is NOT immediately located, call Main Office at _____. Main Office will send the trained delegate, and/or call 911. Main office will also notify covering nurse, if applicable.

5. Calmly reassure student until medical help arrives.

(over)

6. If nurse or trained delegate is available and the student presents with signs of anaphylaxis, care will include _____ (medication, dose, route) and call 911.

7. If student should suffer an anaphylactic reaction, and neither nurse nor trained delegate is available, call 911 and state that the student may be having a severe allergic reaction and ask for emergency services response.

8. Any student receiving epinephrine will be transported o the nearest hospital.

9. Nurse or office will notify parents.

Name of prescribing physician _____ Phone _____

This information will be shared with school staff as deemed appropriate. In addition, it is expected that you, as a parent /guardian will also share your child's medical condition/allergies and treatment with school personnel as needed.

I, parent/guardian agree to the above emergency health care plan and the use of delegates as needed and agree to indemnify and hold harmless the Bergenfield School District and its employees from any claims arising from the administration of the above mentioned medication to my child.

_____ _____

Parent/Guardian Signature Date

EMERGENCY CONTACTS

1. _____

Relationship _____

Phone number _____

2. _____

Relationship _____

Phone Number _____

TRAINED DELEGATES

1. _____

Ext. _____

2. _____

Ext. _____

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____

3/07