

West Morris Regional High School District
Emergency Health Care Plan

Name: _____ D.O.B: _____ Grade: _____

Allergy/Anaphylaxis to: _____

Asthmatic: Yes No (High Risk for Severe Reaction).

Student Responsible and Approved by MD/Parent to Self Carry and Administer

Epi-pens (and Benedryl if ordered) Yes No

Student carries Epi-Pens with him: Yes No

Locations of Epi-Pens: _____

Has student ever had an anaphylactic reaction? Yes No

Signs Of an Allergic Reaction Include:

(Please check the specific symptoms which this student has experienced).

Systems	Symptoms
<input type="checkbox"/> Mouth	itching, swelling of lips, tongue or mouth
<input type="checkbox"/> Throat	itching, tightness of throat, hoarseness, and hacking cough
<input type="checkbox"/> Skin	hives, itchy rash, swelling of face and or extremities, sweating
<input type="checkbox"/> Gut	nausea, abdominal cramps, vomiting, and or diarrhea
<input type="checkbox"/> Lung	shortness of breath, repetitive coughing, and or wheezing
<input type="checkbox"/> General anxiety	

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation!!

Student must carry all necessary medications at all school functions.

Action for Suspected Ingestion/Sting:

1. Immediately administer: _____
and then administer _____.
Administer 2nd epinephrine injection after _____ minutes if symptoms continue.
2. Call Rescue Squad. Stay with student.
3. Call Mother _____ Father _____

Emergency contacts:

Name _____ Phone _____
Name _____ Phone _____
Dr. _____ Phone _____

Do not hesitate to administer the medication or call rescue squad even if parents can not be reached.

Parent signature

Date

MD signature (Please Stamp)

Date

West Morris Central High School

Health Office

Phone: 908-879-5212

Fax: 908-879-5460

Dear Parent/Guardian:

According to regulations which govern us, **SELF-ADMINISTRATION** of any medication by school children is not permitted except in cases of severe asthma or other potentially life-threatening illness. We must have written authorization from the physician and the parent or guardian.

Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.

Kindly complete the attached form and have your child return it to the Health Office. Thank you. Please let us know if your child no longer needs to use an **inhaler** or **EpiPen medication** (See below).

Sincerely,

Susan Moor, RN

REQUEST FOR TREATMENT

PHYSICIAN:

I am treating _____ for _____
student name condition/illness

and prescribe the following medication/treatment _____.

I acknowledge that this pupil is capable of and has been instructed in the proper method of self-administration of this medication.

Date: _____ Doctor's Signature: _____
(PLEASE STAMP)

PARENT:

I request that my child ' _____ be permitted to self-medicate as prescribed above for the following condition: _____.

I acknowledge that the West Morris Regional Board of Education shall incur no liability as a result of any injury arising from self-administration of medication by the pupil and that we the parents shall indemnify and hold harmless the district and its employees against any claims arising out of the self-medication by the pupil. I understand that I am responsible to provide all prescribed medications for my son/daughter in the event of an emergency as per my son/daughter's Emergency Plan as prescribed by our private physician.

Date: _____ Parent's Signature: _____

My child no longer has a need for an inhaler and/or EpiPen _____

Parent Signature

West Morris Central High School

Health Office

Phone: 908-879-5212 ext. 3495

Fax: 908-879-5460

Dear Parent/Guardian,

The protocols for the administration of **Epinephrine** for life threatening allergies. According to P.L. 2007.57 (S79 2R), delegates for epinephrine for school need written permission from the parent. Accompanying permission from the parent must be a current copy of the student's Emergency Care Plan for **Epinephrine** Auto Injector.

A separate **Epinephrine** Auto Injector must be provided by the guardian for the purpose of the delegate's access in the event of an emergency. If not provided a delegate cannot be assigned.

Take note that this form must be returned to the school nurse to keep a record of your wishes to be in compliance with New Jersey code.

The nurse must be informed of field trips or after school activities within 72 hours to make arrangements for trained delegates to cover these activities.

(The parent will be notified in the event that a nurse or delegate cannot be assigned for the off campus activity during school hours. Weekend trips require notice as soon as possible to accommodate your request).

Sincerely,
Susan Moor, RN

Epinephrine Auto Injector Permission

Student Name: _____ Grade: _____

(Check all that apply)

- I give permission
- I do not give permission
- My son/daughter has permission to self manage their allergy and administer their dose of epinephrine. I do not need a delegate or nurse assigned in the event one is not available.

My child's Emergency Care Plan is enclosed to reflect my request for his/her medical care.

I understand that by giving permission for a delegate to be assigned that by child's medical information will be shared with pertinent staff members to ensure proper care of my son/daughter.

The volunteer delegate is trained by the school nurse and may administer **Epinephrine** in the event of an emergency for anaphylaxis in which the school nurse or parent is not available for the _____ school year.

I understand that the district and its agents are acting in good faith and the delegate shall be immune from any civil or criminal liability arising from actions pursuant to this act.

Parent Signature

Date