

**MAINLAND REGIONAL HIGH SCHOOL DISTRICT  
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT**

Student's name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

The above student is allergic to: \_\_\_\_\_

Previous episode of anaphylaxis  Yes  No

**MEDICATIONS**

**ANTIHISTAMINE:** Name \_\_\_\_\_ Dose \_\_\_\_\_

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 \_\_\_\_\_

**EPINEPHRINE:**  EpiPen  EpiPen Jr.  Other \_\_\_\_\_

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 \_\_\_\_\_

**Choose one administration order:**

Give Antihistamine only  Give epinephrine only  \*Delegate will be assigned

Give Antihistamine & Epinephrine at same time  \*Delegate will 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 will give epinephrine and any antihistamine order will be disregarded**

This student has been trained and is capable of self-administration of the following medication(s) named above.  epinephrine – single dose unit  Epinephrine & antihistamine – single dose units

\*Under NJ state law, orders for antihistamine alone cannot be self administered

This student is not capable of self-administration of the medications named above.

Physician's signature \_\_\_\_\_

Phone number \_\_\_\_\_

Date \_\_\_\_\_

Stamp \_\_\_\_\_



**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**

Select one to sign and date.

1. I verify that my child \_\_\_\_\_ has a potentially life threatening illness and **has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self administer prescribed medication.** I further acknowledge that the Mainland Regional High School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by NJ law and Mainland Regional High School District policy are followed, I shall indemnify and hold harmless the Mainland Regional High School District and it's employees or agents against any claims arising out of self administration of medication by my child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

2. 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 further acknowledge that the Mainland Regional High School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Mainland Regional School District Policy are followed, I shall indemnify and hold harmless the Mainland Regional School District and it's employees or agents against any claims arising out of administration of medication to my child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Please sign

I understand that under NJ state law, a trained delegate will be assigned to administer epinephrine to my child **in the absence of a school nurse**. 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.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**SCHOOL USE ONLY**

\_\_\_\_\_  
Signature of School Nurse

\_\_\_\_\_  
Date