FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

REQUIREMENTS FOR ALLERGIC STUDENTS USING EPINEPHRINE AUTO INJECTORS
FORM 02-D-37
Required forms for 5th – 12th grade students with allergies.

Dear Parent or Guardian of _____Grade/Teacher_____.

The below items are necessary in order to complete your child's medical file for the school year _____ - _____. Allergy forms must be renewed annually for each school year.*

1. The completion of the **Epinephrine Administration of Medication (02-D-34-D)** form for the administration of the Epinephrine Auto Injector

   Self-Administration of Medication (02-D-34-E) form would only be used for appropriate age and trained students with a separate form signed by their healthcare provider and parent. **This is a mandatory requirement on the high school level and for students who participate in after-school activities and school sponsored sport activities.**

2. The completion of the **Antihistamine Administration of Medication Form (02-D-34-C)** is optional, and is in addition to the administration of the Epinephrine Auto Injector during school hours only. *This medication can only be administered by a school nurse during school hours.*

3. The completion of the **Food Allergy & Anaphylaxis Emergency Care Plan** (2 pages).

4. The completion and notarization of the **Indemnification (02-D-44)** form for the above mentioned school year. *(For the administration of Epinephrine Auto-injectors only)*

5. A copy of the results of the most recent RAST and or Skin Test done on your child.

6. Properly labeled by the pharmacy medication must be given to the school nurse.

**All items must be completed in order for the school nurse to give any medication to your child.*

** *Please write down the expiration dates for all medication given, and replace as needed, after the medication expires. All medication must be picked up at the end of the school year.*

Thank you for your continued cooperation.

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

SCHOOL YEAR 20 -20
EPINEPHRINE ADMINISTRATION OF MEDICATION FORM
FORM 02-D-34-D

To be completed by the examining physician and parent and returned to the School Nurse/Teacher.

Permission is effective only for the school year for which it is granted and must be renewed annually. Medication must be in ORIGINAL container, appropriately labeled by the pharmacy or physician.

Student's Name _____ DOB _____ Grade _____
(Last) (First)

A. TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS _____

NAME OF THE MEDICATION: EPINEPHRINE AUTO INJECTOR

BRAND NAME _____ MANUFACTURER _____ EXPIRATION DATE ____

DOSAGE _____

FREQUENCY _____

FOLLOW – UP INSTRUCTIONS _____

_____ _____
Physician Signature **Date**

_____
Physician Printed Name

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

B. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I understand that the district and its employees or agents shall incur no liability as a result of injury arising from the administration of medication. I indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of medication.

_____ _____
Parent/Guardian Signature **Date**

_____
Parent/Guardian Printed Name

C. TO BE COMPLETED BY HEALTH SERVICES STAFF:

Form reviewed _____ (Date) _____

_____ _____
School Physician's Signature School Nurse/Teacher's Signature

REV. 02/09/2022

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

ANTIHISTAMINE ADMINISTRATION OF MEDICATION FORM (FOR LIFE THREATENING ALLERGIC REACTION IN ADDITION TO THE FARE EMERGENCY CARE PLAN)
FORM 02-D-34-C

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: _____ Date of Birth: _____

Allergies: _____ Grade: _____ Current Weight: _____

Diagnosis/Medical Condition: _____

Name of Antihistamine: _____ Dose to be administered: _____

Route: _____ Time to be administered: _____ am/pm (please circle)

Possible side effects of medication: _____

Intervention to be rendered for an adverse reaction: _____

_____

* _____ _____ | |
PHYSICIAN SIGNATURE DATE

* _____ PHYSICIAN STAMP
PHYSICIAN PRINTED NAME (TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: _____
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: _____
- I am aware that this medication can only be administered by a school nurse during school hours. Initial: _____

_____ _____ _____
Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by _____ **School Nurse-teacher**
Name **School Doctor**

On _____.
Date

REV. 02/09/2022

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

SCHOOL YEAR 20 -20
SELF-ADMINISTRATION OF MEDICATION REQUEST FOR LIFE THREATENING ALLERGIC REACTION REQUIRING EPINEPHRINE (IN ADDITION TO THE FARE EMERGENCY CARE PLAN)
FORM 02-D-34-E

To be completed by the examining physician and parent and returned to the School Nurse/Teacher.

Permission is effective only for the school year for which it is granted and must be renewed annually. Medication must be in ORIGINAL container, appropriately labeled by the pharmacy or physician.

Student's Name _____ DOB_____ Grade _____
(Last) (First)

A. TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS _____

NAME OF THE MEDICATION: EPINEPHRINE AUTO-INJECTOR

BRAND NAME_____MANUFACTURER_____EXPIRATION DATE____

DOSAGE _____

FREQUENCY _____

FOLLOW – UP INSTRUCTIONS _____

The above named student is permitted to keep / carry the said medication and is capable of self-administering the medication as needed. I certify that the student has been instructed by me and understands the purpose and appropriate method and frequency of use of this medication.

_____ _____
Physician Signature **Date**

_____
Physician Printed Name

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

B. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request that my child be allowed to carry/keep and self-administer the above medication as indicated by the physician. I verify that my child knows how to correctly administer the medication.

I understand that the district and its employees or agents shall incur no liability as a result of injury arising from the self-administration of medication by the student to himself/herself or other persons as a result of misuse. I indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration or non-administration of medication by the student.

_____ _____
Parent/Guardian Signature **Date**

_____
Parent/Guardian Printed Name

C. TO BE COMPLETED BY HEALTH SERVICES STAFF:

Form reviewed _____ (Date) _____

_____ _____
School Physician's Signature School Nurse/Teacher's Signature

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

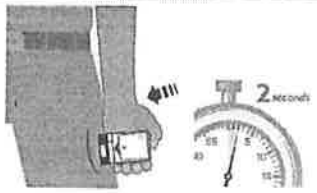
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

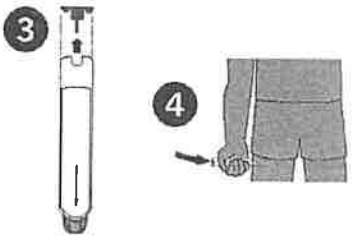
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



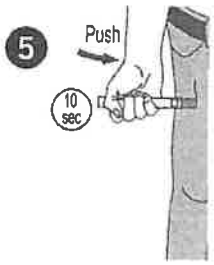
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

EMERGENCY ADMINISTRATION OF EPINEPHRINE
STATEMENT OF INDEMNIFICATION

NOTARIZATION REQUIRED

02-D-44

1. **I am the parent or guardian of_____, a student currently enrolled in the Fort Lee Public Schools.**

2. **I have provided to the Board of Education, through its administration, written certification from _____'s physician or advanced practice nurse attesting to the fact that_____ requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication.**

3. **On _____I provided to the Board of Education, through its administration, two (2) current pre-filled, single dose auto-injector mechanisms, containing epinephrine for the use of my child, _____. The epinephrine I provided is due to expire on_____. I understand that epinephrine can only be obtained through a prescription and that I am fully responsible for keeping track of the expiration dates of said epinephrine and replacing the same with pre-filled, single dose auto-injector mechanisms containing epinephrine when they have expired.**

4. **When required, and in accordance with the procedures specified by N.J.S.A. 18A:40-12.5 and N.J.S.A. 18A:40-12.6, I hereby consent, via this writing, to the administration of this pre-filled, single dose auto-injector mechanism containing epinephrine, which I provided to the Board of Education, to my child, _____.**

5. **The Board of Education, through its administration, has informed me in writing that if the procedures specified in N.J.S.A. 18A:40-12.5 and N.J.S.A.18A:40-12.6 are followed, the Board and/or it's employees or agents shall incur no liability as a result of any injury arising out of its administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child, _____.**

6. **This statement acknowledges that where the procedures specified in N.J.S.A. 18A:40-12.5 and N.J.S.A. 18A:40-12.6 are followed, the district shall have no liability and further acknowledges that I hereby indemnify and hold harmless the district and employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child, _____.**

7. **I understand that the permission being granted for the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child is effective only for the school year for which such permission is granted and must be renewed for each subsequent school year.**

_____ _____

Parent or Guardian's Signature **Date**

Sworn and Subscribed Before Me

This_____ Day of_____2_____.

_____.