Summit Public Schools

MEMO

To: Parents of Children prescribed Epinephrine for Anaphylaxis

From: Summit School Nurses

RE: New Jersey P.L. 2007, c.57. and Epinephrine Auto-Injector Packet

In 2007, the New Jersey Legislature amended N.J.S.A. 18A: 40-12.3-12.6. to address the administration of epinephrine to students in New Jersey schools and to include additional protocols for the delegation of another district employee, who has volunteered and is properly trained, to administer epinephrine via a prefilled auto injector to a pupil experiencing anaphylaxis. The school nurse will choose and designate in consultation with the Board of Education, a delegate who will be trained to administer one dose of epinephrine via a pre-filled auto injector, in the absence of the school nurse, when the nurse is not physically present.

Please keep in mind that the delegate is a volunteer, must be willing to learn the procedure, assume the responsibility and successfully complete the training, demonstrating competency. The delegate must be available in the environment where anaphylaxis is most likely to occur and cannot further delegate that task to anyone else. Every effort will be made to obtain and train a delegate(s) for your child, however in the event that there is no delegate available and in the absence of the school nurse, if medication is not available or you have not replaced an expired medication, emergency management via a 911 call will be implemented.

In best meeting the health needs of your child with a life threatening allergy, we must implement school wide protocols for managing a potential medical emergency, including an Individualized Health Care Plan and Emergency Plan, which is a collaborative effort between parents, school staff and your child's health care provider.

Enclosed are several forms that must be completed by your child physician in addition to the parental information, signatures and consents, all which are required. These forms include:

- **Private Health Care Provider Letter**
- **Medication Authorization Form School Nurse and Delegate Emergency Allergy Action Plan. *Parents must complete reverse (pg2) and sign*.**
- **Student Allergy Information Nursing Assessment** (To be completed by Parent)
- **Individualized Health Plan: Prevent Anaphylaxis** (Parent review and signature)

Please make sure that you allow sufficient time for your health care provider to complete these forms**. The plan cannot take effect until all required documents are completed with ALL appropriate signatures, provider's office stamp and documents are received in the Health Office along with the prescribed pharmacy labeled medications**. Please call our office to schedule a meeting to determine how to best implement this plan. Return all forms on or before the first day of the school year, or the first day your child is returning to school after the medication has been prescribed.

Thank you for your anticipated cooperation.

Summit Public Schools

MEMO

To: Padres de Estudiantes con receta para Epinephrine para prevenir Anaphylaxis

From: Summit School Nurses

RE: New Jersey P.L. 2007, c.57. and Epinephrine Auto-Injector Packet

La legistación de Nueva Jersey en el 2007 acerca de la administración de epinephrine a los estudiantes en las escuelas, incluye que otro empleado del districto, voluntario puede ser entrenado apropriadamente para administrar la epinephrine auto-injectable a un pupil que esperiencia anaphylaxis. La enfermera escolar escogerá el designado empleado, siguiendo las normas de la Board of Educación y este podrá administrar una dosis de epinephrine auto-injectable en la ausencia de la enfermera, cuando la enfermera no este presente.

Se tratará lo más posible de obtener un voluntario que se pueda entrenar y delegar. Si no hay delegado apropiado y en la ausencia de la enfermera, si no hay medicamento en la escuela, o si usted no ha traido un medicamento despues que el otro expire, 911 seá llamado para asistir al estudiante.

También necesitamos implementar un Plan individualizado de cuidados y de emergencia, colaborando con los padres, los maestros y su proveedor de salud (medico).

Aquí tienen varias formas que deben ser completas por su medico, ademas de información de los padres, firmas y autorizaciones. Todo esto es requerido para asistir a su hijo (a). Las formas incluyen:

- **Carta para el proveedor de salud (Medico)**
- **Medication Authorization Form School Nurse Allergy Action Plan (Medico) and Delegate Allergy Emergency Action Plan (Medico) *Los padres deben completar la pagina 2 (reverso) y firmar***
- **Student Allergy informacion de salud (completo por los padres)**
- **Individuallized Health Plan: Prevencion de Anaphylaxis (padres deben revisar y firmar)**

Todas las formas deben ser completas, con firmas de los padres y del medico, también la estampa de la oficina del medico. Las medicinas deben venir a la escuela con la información y etiqueta intacta de la farmacia.

Devuelva todas las formas y traiga los medicamentos tan pronto empieze su hijo(a) la escuela o el primer dia de retorno a la escuela, despues que el medico ha recetado estos medicamentos para prevenir Anaphylaxis.

Gracias por su cooperación.

Summit Public Schools

Dear Physician:

According to the Emergency Administration of Epinephrine *New Jersey Public Law 2007, c. 57* a lay person (designee) is allowed to administer a prefilled Epinephrine auto injector in the event of an emergency allergic reaction occurring during the school day or during school sponsored functions. This only applies in the event that the school nurse is not physically present, the child's parent/guardian is not available or you have indicated the child is not permitted to self-administer.

The Medication Authorization Form School Nurse and Delegate Allergy Action Plan allows you to provide medication orders for administration of Epinephrine by the school nurse and delegate. You may indicate if the child is capable of self-administering the auto injector or may self-administer a single pre-measured dose of antihistamine when age appropriate.

Written medical orders are required in order for the school nurse to train the designee appropriately. These orders apply to a prefilled auto-injector mechanism and the designee may administer only one dose. The designee is not qualified to assess the progression of symptoms and the status of the child; therefore any written orders requesting for any other medication to be administered will not be able to be given by the designee.

Please complete the **Medication Authorization Form Nurse and Delegate Allergy Action Plan.** Please include previous use of epinephrine and child's weight. Written orders for the designee will apply to **ONE dose only** of a prefilled epinephrine auto-injector.

Your signature and office stamp are required on Medication Form.

Thank you very much for your cooperation.

Sincerely,

The Summit School Nurses

Student Photo

Summit Public Schools

Medication Authorization Form Nurse and Delegate Allergy Action Plan

Student's Name:_____**D.O.B:**_____**Teacher/HR:**_____**Grade**_____

ALLERGY TO:_____Child's **Weight**_____ **lbs / kg**

Asthmatic Yes* □ No □ *Higher risk for severe reaction Previous use of Epinephrine Y / N (when):_____

Any SEVERE SYMPTOMS after suspected or known ingestion/insect sting or contact with allergen:		**Nurse or Delegate**
One or more of the following: **LUNG:** Short of breath, wheeze, repetitive cough ***HEART:*** *Pale, blue, faint, weak pulse, dizzy, confused* **THROAT:** Tight, hoarse, trouble breathing/swallowing **MOUTH:** Obstructive swelling (tongue and/or lips) **SKIN:** Many hives over body Or **combination** of symptoms from different body areas: **SKIN:** Hives, itchy rashes, swelling (eyes, lips, etc) **GUT:** Vomiting, diarrhea, crampy pain	→	**1. INJECT EPINEPHRINE IMMEDIATELY** (circle one) **EpiPen®** **EpiPen® Jr.** **Auvi-Q™ 0.3mg** **Auvi-Q™ 0.15mg** **2.** Call **911** ***3.*** Begin Monitoring (see box below) 4. **NURSE ONLY** *give any additional medication prescribed* *Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis. USE **EPINEPHRINE** Administer intramuscularly or subcutaneously lateral aspect of thigh

†Potentially life-threatening. The severity of symptoms can quickly change

MILD SYMPTOMS ONLY:		
MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea / discomfort	→	1. Stay with student; **alert health care professional; alert parent** 2. If symptoms progress USE EPINEPHRINE 3. Begin Monitoring (see box below) 4. **Nurse ONLY GIVE ANTIHISTAMINE** □ Diphenhydramine (Benadryl) □ Cetirizine (Zyrtec) Dose:_____cc (_____mg) orally by mouth

ADDITIONAL MEDICATION DOSAGE (School Nurse ONLY)

School Nurse Only □ Repeat Epinephrine dose via auto injector in _____minutes.

Other: Nurse Only_____

Medication/dose/route/Possible side effects

Extremely reactive to:	**THEREFORE** If checked □ Give epinephrine immediately if the allergen was definitely eaten/contacted or insect sting **even if no symptoms are noted.**

MONITORING:	**STUDENT SELF ADMINISTRATION** - Check all that apply
Stay with student; alert health care professionals and parent. **Call 911**-state that a severe allergic reaction has been treated, additional epinephrine may be needed and **PARAMEDICS** are needed. Note time epinephrine was given; for a severe reaction consider keeping student lying on back with legs raised. Even if Parent/Guardian cannot be reached **DO NOT HESITATE to medicate. Student MUST be transported to Hospital**	□ This Student is capable of and has been instructed in, the proper administration of: □ Epinephrine Auto injector single dose unit □ Antihistamine Single Pre-measured Dose □ Student is permitted to carry prescribed medication and self-administer in school or school sponsored events □ Student is aware he/she must report any suspected exposure to an allergen, any signs of an allergic reaction and any use of prescribed medication IMMEDIATELY

Provider Office Stamp

Doctor/Nurse Practitioner Signature_____ _____

Required Date

May 2013 **Adapted from FARE 5//2013 (www.foodallergy.org)** **TURN FORM OVER**

Statement Summit Public Schools

This student has a potentially life threatening allergy that can result in anaphylaxis. Parent/Guardian gives consent and request administration of epinephrine via a prefilled single dose auto injector mechanism and medications as prescribed, to student by the school nurse or 1 dose only of epinephrine via auto injector by the properly trained district employee(s) according to district protocol/policy, chosen by the school nurse as a designated person(s) to administer epinephrine in an emergency when school nurse is not present. Permission is effective this school year only and must be renewed each subsequent year upon fulfillment of requirements stated in NJSA 18:A:40-12.6. Parent agrees to indemnify and hold harmless the Summit Public School District, the Board, its members, its employees or agents of any liability as the result of any injury arising from the administration of epinephrine via auto injector to the above named student. Parent/Guardian agrees to provide a current epinephrine pre-filled auto injector(s) in addition to any medication here by prescribed, in its original labeled box from the pharmacy and replace medications upon expiration, use or any dosage change as prescribed by Private Care Provider. Parent will contact the School Nurse informing of any school sponsored extracurricular activities child will participate during the school year. Parent will also contact the Coach, Classroom Teacher and/or Staff in Charge of any school sponsored extracurricular activity and will inform them of child's allergy. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

My child has a potentially life threatening allergy that can result in anaphylaxis. I hereby give consent to permit properly trained district employee(s) according to district protocol and policy, chosen by the school nurse as a designated person/persons to administer epinephrine via a prefilled single dose auto-injector mechanism, to my child in an emergency and in the absence of the school nurse when the nurse is not physically present.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Parent/Guardian's Signature_____ _____

Required **Date**

EMERGENCY CALLS*

Dr._____ Phone_____

Parent:_____ Phone_____ (C) Phone _____(W)_____

Parent::_____ Phone_____ Emergency contact:_____Phone:_____

LOCATION OF EPINEPHRINE:

_____ With Student

_____ Nurses Office

_____ Other Secured Location/Where: _____

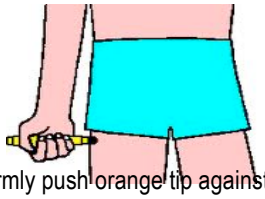
Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2". Place RED rounded tip against outer thigh, press down hard. Hold for 10 seconds, then remove.

EPiPEN® Auto-Injector and EpiPEN Jr.® Auto-Injector Directions

- First, remove the EpiPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



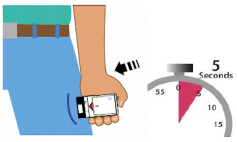
- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove EpiPEN Auto-Injector and massage the area for 10 more seconds

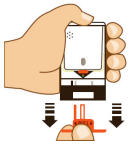
EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P

Auvi-Q ™(epinephrine injection USP)

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard





Place black end against outer thigh, press firmly, hold for 5 seconds

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

SUMMIT PUBLIC SCHOOLS

Student Allergy Information Nursing Assessment
(To be completed by Parent)

Student Name_____D.O.B._____ Teacher_____

Indicate Allergies:

_____Insect Stings (circle): Bees Wasp Other:_____

_____Food (circle): Peanut Tree Nuts Milk Soy Eggs Fish Shellfish

Other:_____

_____Latex Allergy Other contact Allergy:_____

_____Drug/Medication Allergy (List): _____

List symptoms when reaction occurred:

_____Breathing difficulty _____Coughing _____Wheezing

_____Swallowing difficulty _____Vomiting _____Loss of Consciousness

_____Swelling: Describe Location & Severity_____

_____Hives location:_____Other:_____

Most recent reaction date:_____ Epinephrine needed? Yes / No
Has Epinephrine ever been administered? Yes / No Date administered:_____
Hospitalization or emergency room care needed in the past year for allergies? Yes / No
Does your child know how to self-administer Epinephrine Auto-injector? Yes / No
Has your child's physician instructed your child on its use? Yes / No
Indicate medication use (required) and any additional details:

_____
Are there any other changes in your child's health since last September?_____
Are you available to go on class trips? Yes / No
_____I will provide my child with his/her own snack for the classroom

I have read and reviewed the Medication Administration for the Nurse and Delegate order Allergy Action Plan and IHP (reverse side or p.8) and understand the content of each form. I will provide the School Nurse with information related to changes in my child's condition, treatment or medication, occurring during the school year. I will contact the School Nurse informing of any school sponsored extracurricular activities my child will participate during the school year. I will also contact the Coach, Classroom Teacher and/or Staff in Charge of any such extracurricular activity and will inform them of my child's allergy. Permission is granted for Nurse to share information regarding my child's life threatening allergy with teaching staff. Information regarding my child's life threatening allergy **may also** be shared with the following ***(Parent MUST initial for approval):***

_____Classmates _____Families of classmates

_____My child's name may be included when notifying as approved

Parent/Guardian Signature:_____ **Date:**_____

ESCUELAS PÚBLICAS DE SUMMIT

Información sobre Alergias del estudiante, Evaluación de Enfermería
(Para ser completado por los padres)

Nombre del Estudiante _____Fecha de Nacimiento _____Maestro_____

Indique Alergias:

_____Picaduras de insectos (círcule) : Abejas o Avispas Otros : _____

_____Comida (Haga un círculo) : Cacahuete Nueces de Árbol Leche Soja Huevos
Pescado/Marisco Otro: _____

_____Latex Alergia Alergia a otro contacto : _____

_____ Alergia a Medicamentos (Lista) : _____

Lista de los síntomas cuando se produjo la reacción :

_____ Dificultad respirando _____ Tos _____ Silbido al respirar

_____Dificultad al tragar _____ Vómitos _____ Pérdida del conocimiento

_____Hinchazon/ Edema : Describir donde y severidad_____

_____Urticaria donde : _____Otra reaccion: _____

La reacción mas reciente : _____ Necesito Epinefrina Sí /No_
Alguna vez se le ha administrado epinefrina Sí / No Fecha administrada : _____
Hospitalización o emergencia necesario en el pasado año para las alergias Si / No
¿Sabe su hijo cómo autoadministrarse la epinefrina auto - inyector ? Si / No
Ha dado instrucciones su médico a su hijo en el uso de epinefrina? Indique el uso de medicamentos necesarios y detalles adicionales:
_____
¿Hay otros cambios en la salud de su hijo desde el pasado ano en Septiembre ? _____
¿Está usted disponible para ir de viajes de la clase ? Sí / No
_____Yo le mando a mi hijo(a) su propia merienda para el aula

He leído y revisado la Administración de Medicamentos para la Enfermera y el Plan de acción del Delegado y Plan de Salud (pagina.8) y comprendo el contenido de cada formulario. Le dejare saber a la enfermera de la escuela información relacionada con cambios en la condición, el tratamiento o la medicación de mi hijo, que ocurran durante el año escolar. Me pondré en contacto con la enfermera de la escuela informando de todas las actividades extracurriculares patrocinadas por la escuela en la cual mi hijo participará durante el año escolar. También me pondré en contacto con el entrenador, los maestros y el personal a cargo de cualquier actividad extracurricular y les informaré de la alergia de mi hijo. Se concede permiso para que la enfermera de información sobre la alergia que puede causar peligro de vida a mi hijo, con el personal de ensenanza. La información sobre la alergia de peligro de vida de mi hijo también puede ser compartida con los siguientes ***(padres deben poner sus iniciales) :***

_____ Compañeros de clase _____ Las familias de los compañeros de clase

_____El nombre de mi niño puede ser incluido para notificar segun aprobado

Padre / Tutor Firma: _____ Fecha: _____

INDIVIDUALIZED HEALTH CARE PLAN

NAME: **DOB:** **SEX: F / M** **ALLERGIES:** **PHYSICIAN:**
RELEVANT DIAGNOSES:
DIET: Free from foods **NO Peanut/Nut/ Milk/Dairy/Eggs/Soy/** **EQUIPTMENT:** **Emergency Plan in Place**
containing allergen **Other:** **LATEX** **MOBILITY:** **Delegate available Yes / No**
MEDICAL HISTORY: ALLERGY TO FOOD / Contact / Insect Bites
MEDICATION/ TREATMENT: **EPI-PEN Jr. / Sr.** **Auvi-Q mg** **Medication Available Yes / No**
SIGNATURE: SIGNATURE: **SIGNATURE:**
(Parent) (Student-age appropriate) (School Nurse)

DATE	HEALTH PROBLEM/ NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE
	Potential for alteration in breathing patterns/gas exchange related to bronchospasm and inflammation of the airway if exposure to allergen. (NANDA 1.5.1.1) Potential for Knowledge deficit about anaphylaxis and/or allergen. (NANDA 8.1.1) Potential for noncompliance with prescribed medication(s) related to knowledge deficit regarding need for emergency medication administration. (NANDA 5.2.1.1) Medication supplied to Health office with completed orders Yes / No	Student will be able to state food allergen. Student will have knowledge to avoid contact or ingestion of food allergen. Student will be able to participate in school activities and trips with modifications as needed. Student will not experience Anaphylaxis.	Nurse will educate Staff/Student re: Allergen signs/symptoms of allergic reaction. Development of Emergency Plan including accommodations needed for Class Trips & school sponsored Extracurricular activities. Parent available for trip Yes / No Notification of Food Services, Cafeteria Personnel, PTA/Class mothers of need for allergen free food and/or party supplies for classroom. Parent will supply prescribed medication & orders (according to SBOE policy) and will inform Nurse of any school sponsored extracurricular activity involvement and contact such said Coach/Teacher/Staff. Student will be provided with alternate meals or snacks when needed. Informational material distributed to school Staff in September re: Anaphylaxis Management Letter re: Food Allergies sent home to classroom students Nurse or Trained Designee will administer medication as per order (SBOE anaphylaxis Protocol)	Yearly or PRN. Student will be able to participate in classroom/school activities with modifications PRN. Staff (teachers, assistants, and cafeteria personnel) will have knowledge of student's allergen. Student will be able to recognize signs & symptoms (i.e. shortness of breath, itchy, hives) and advise teacher/adult in charge/nurse if experiencing symptoms. Student will immediately inform teacher/adult in charge/nurse if suspected ingestion or contact to allergen has occurred. Student will be aware of allergen and avoid contact or ingestion.

PRN=As needed SBOE= Summit Board of Education (Rev 2013)