Lodi Public Schools
Lodi, New Jersey

Lodi Public Schools Permission Slip
and
Hold Harmless Agreement Administration of Epinephrine

I (we), the undersigned parent/guardian of _____ request that the school nurse administer, as per the written orders of Dr._____, epinephrine via an epi-pen, provided by me, to my child named above.

I have read the attached Lodi Board of Education Policy #5330 and fully understand that:

1. I must provide a filled single dose auto injector mechanism containing epinephrine.
2. The doctor's order must provide the name of the medication, the purpose of its administration, it's proper timing, it's dosage, it's possible side effects, and the date of discontinuance.
3. The written orders from your physician must state that the above-named student requires the administration of epinephrine via the epi-pen for anaphylaxis and is unable to self-administer.

I (we) _____ hereby acknowledge that if the Lodi Board of Education procedures are followed, the Lodi Board of Education shall incur no liability whatsoever for any and all claims, damages, losses, and expenses of any kind including reasonable attorney's fees as a result of any injury which arises from the emergency administration of an epi-pen as prescribed my physician. I hereby indemnify and hold harmless the Lodi Board of Education and its employees, officers, or agents against any and all claims arising from the emergency administration of the epi-pen.

You are hereby given notice that none of the schools in the Lodi Public School District has an appointed designee to administer said epi-pen if the school nurse is unavailable. In such an event the 911 procedure will be implemented. Your signature indicates you have read and are aware of the above and agree for the school nurse to release your child's name to the appropriate individuals in the school so that they are aware and can implement the 911 procedure in the event the school nurse is unavailable. These individuals may include but not be limited to the principal, vice principal, director of food services, physical education teacher and coaches, secretary, and classroom teachers.

I hereby acknowledge our full understanding of and agree to the above by my signature below.

Date:_____ Signature of Parent/Guardian:_____

Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?

❑ Peanuts	❑ Insect Stings
❑ Eggs	❑ Fish/Shellfish
❑ Milk	❑ Chemicals _____
❑ Latex	❑ Vapors _____
❑ Soy	❑ Tree Nuts (walnuts, pecans, etc.)
❑ Other: _____	

b. Age of student when allergy first discovered:_____
c. How many times has student had a reaction?
❑ Never ❑ Once ❑ More than once, explain:
_____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ❑ Same ❑Better ❑ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
_____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. Please check the symptoms that your child has experienced in the past:

Skin:	❑ Hives	❑ Itching	❑ Rash	❑ Flushing	❑ Swelling (face, arms, hands, legs)
Mouth:	❑ Itching	❑ Swelling (lips, tongue, mouth)			
Abdominal:	❑ Nausea	❑ Cramps	❑ Vomiting	❑ Diarrhea	
Throat:	❑ Itching	❑ Tightness	❑ Hoarseness	❑ Cough	
Lungs:	❑ Shortness of breath		❑ Repetitive Cough		❑ Wheezing
Heart:	❑ Weak pulse	❑ Loss of consciousness			

4. Treatment

a. How have past reactions been treated? _____
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____
e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
_____
f. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
g. Have you used the treatment or medication? ❑ No ❑ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ❑ No ❑ Yes
b. Does your student:
   1. Know what foods to avoid ❑ No ❑ Yes
   2. Ask about food ingredients ❑ No ❑ Yes
   3. Read and understands food labels ❑ No ❑ Yes
   4. Tell an adult immediately after an exposure ❑ No ❑ Yes
   5. Wear a medical alert bracelet, necklace, watchband ❑ No ❑ Yes
   6. Tell peers and adults about the allergy ❑ No ❑ Yes
   7. Firmly refuses a problem food ❑ No ❑ Yes
c. Does your child know how to use emergency medication? ❑ No ❑ Yes _____
d. Has your child ever administered their own emergency medication? ❑ No ❑ Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? _____
b. Does your child carry epinephrine in the event of a reaction? ❑ No ❑ Yes
c. Has your child ever needed to administer that epinephrine? ❑ No ❑ Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy? _____

7. General Health

a. How is your child's general health other than having a food allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of asthma? ❑ No ❑ Yes
   If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes
e. Please add anything else you would like the school to know about your child's health: _____
   _____

8. Notes:

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

Reviewed by R.N.: _____ **Date:** _____

Adapted with permission – Washington State Guidelines for Anaphylaxis

ROOSEVELT SCHOOL

435 Passaic Aveneue • Lodi, New Jersey 07644 • Phone: (973) 777-5362

MEDICATION AUTHORIZATION FORM

School Year: ..... School: .....

PHYSICIAN'S ORDER

Student: ..... DOB: .....

Medication: ..... Dosage: .....

Time: ..... Frequency: .....

(If a PRN Medication please indicate the frequency with which it can be repeated)

Reason for Medication: .....

Possible Side Effects: _____

Date medication is to be discontinued: .....

Physician's Comments *(if needed):* .....

Date: ....

Physician's Signature

Please Stamp

_____

Address

_____

Telephone

I request that my son/daughter ..... ,be administered the Medication prescribed above by the school nurse.

Date: ..... Signature: .....

Parent/Guardian

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following allergens:_____

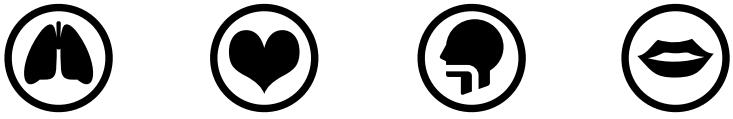
THEREFORE:

☐ 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

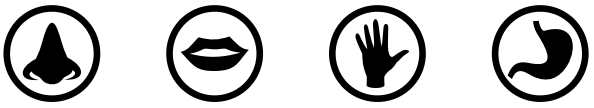
OTHER
Feeling something bad is about to happen, anxiety, confusion

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

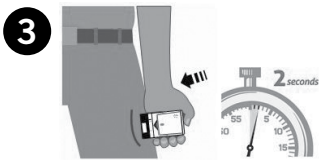
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

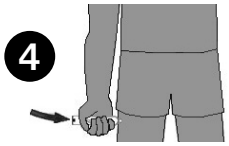
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



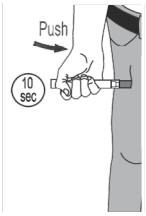
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



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

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. 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. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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) 5/2020

EPI-PEN MEDICATION FORM

Name..... **DOB**..... **Teacher**.....

ALLERGY TO---------- **Asthmatic ___ Yes ___ No (check one)**

STEP 1 - TREATMENT

SYMTPOM	Give Epinephrine	Give Antihistamine
If a food allergen has been ingested but no symptoms:		
• Mouth: Itching, tingling or swelling of lips, tongue, mouth		
• **Skin:** Hives, itchy rash, swelling of face or extremities		
• Gut: Nausea, abdominal cramps, vomiting, diarrhea		
• Throat: tightening of throat, hoarseness, hacking cough		
• Lung: Shortness of breath, repetitive coughing, wheezing		
• Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness		
• Other		
• If reaction is progressing (several of the above) give:		

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen Epipen, Jr Twinject 0.3 mg Twinject 0.15mg

Antihistamine Administer ----------
(medication/dose/route

PERMISSION TO SELF ADMINISTER

This student is both capable and responsible for self-administering this medication:

_____No _____Yes - Supervised _____ Yes - Unsupervised

STEP 2 - EMERGENCY CALLS

1. Call 911- State that an allergic reaction has been treated and additional epinephrine may be needed
2. **Parent** _____ **Phone#**_ _ _ _ _ _ _ _ _ _ _ _ _ _ _
3. **Parent** _____ **Phone#** _____

Emergency Contacts: Name & Relationship

_____ **Phone#**_____ _

_____ **Phone#**.....

DOCTOR'S SIGNATURE _____ Date _____

(Required)

PARENT/GUARDIAN SIGNATURE_____ Date _____

THOMAS JEFFERSON MIDDLE SCHOOL

75 First Street • Lodi, New Jersey 07644 · Phone: (973) 478-8662 • Fax: (973) 478-0358

ROOSEVELT SCHOOL

435 Passaic Avenue - Lodi, New Jersey 07644 - Phone: (973) 777-8511 Fax: (973) 249-0840

Date: _____

Dear Parent/Guardian of: _____

You have indicated that the above-named student has an allergy to _____ _____. Please advise the nurse at your child's school what the exact reaction your child has and if any medication is required in the event of a reaction.

ALLERGIES

It is IMPERATIVE that you notify the school nurse if your child has any significant allergies i.e. peanut, medication, bee sting as soon as possible and what the specific reaction is and the course of treatment to be taken. If your child requires medication of any type to counteract their reaction please contact the nurse at your child's school for the proper forms.

_____ has an allergy to: _____
Student's Name

_____. He/she requires _____

_____

Date: _____ _____
Parent's Signature

ROOSEVELT SCHOOL

435 Passaic Avenue - Lodi, New Jersey 07644 - Phone: (973) 777-8511 Fax: (973) 249-0840 www.lodi.k12.nj.us

Date: _____

Dear Parents/Guardians:

Allergies

Anaphylaxis is a potentially severe or life-threatening allergic reaction that can occur very quickly-as fast as within a couple of minutes of exposure to an allergen.
It can be triggered by an allergy to a particular food (peanuts or shellfish, for example), biting or stinging insects (like bees), medication (penicillin is a common one), latex (the type of rubber many balloons are made from) or a variety of other allergic triggers. If your child requires medication of any type to counteract their reaction please contact the nurse at your child's school for the proper forms.

Students Name_____ has an allergy to: _____

Student requires epi pen at school: circle one agree disagree

Date:_____

Parent Signature:_____

ROOSEVELT SCHOOL

435 Passaic Avenue - Lodi, New Jersey 07644 - Phone: (973) 777-8511 Fax: (973) 249-0840

Date: _____

Dear Parent/guardian of: _____

Please have the-enclosed medication form completed for the _____ school year

Be sure your physician completes all pertinent areas. He/she must Sign and date it as well as stamp the box. on the bottom.

You must sign the bottom portion of the form.

Return to the school nurse as soon as possible.

No medication-can be dispersed without the form being completed in its entirety.
Sincerely,

Joanne Tarabocchia RN, BSN
Roosevelt School Nurse

School Nurse
Telephone Number 973-777-5262