University UrgiCare

EMMERGENCY ADMINISTRATION OF EPI-PEN (EPINEPHRINE) AT SCHOOL

May 20, 2015

Dear parent/ guardian:

New Jersey P.L. 2007, c57. And N.J.S.A. 18A:40-12.3-12.6 allows trained delegates for students who may require emergency administration of epinephrine by auto-injector for anaphylaxis when the school nurse is unavailable. The attached form is required for your child to receive epinephrine by auto-injector.

This form gives the school district permission to allow for the school nurse and trained employees (delegates) of the school district to administer epinephrine via auto-injector when the school nurse is not physically present at the scene. **It is in your student`s best interest to allow your student to have at least one trained delegate at school**.

In addition to the second part this form allows your child to carry and self administer epinephrine by auto-injector and diphenhydranmine. I urge you to discuss this with your medical provider. **We strongly encourage all middle and high school students to be trained to carry and self administer epinephrine by auto-injector and diphenhydramine**. Please note that this may not be appropriate for students in elementary grade levels.

Please return the form and two Epi-Pen or Epi-Pen Jr to the school nurse as soon as possible. If you have any questions regarding these forms please do not hesitate to contact the school nurse.

Sincerely,

Sathesh Porur Evalappan M.D.,
School Medical Inspector

1553 Hwy 27, Suite #2100, Somerset, NJ 08873 855-4-MY-URGI (855-469-8744)

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE AT SCHOOL

Student Name: _____ DOB: _____ Grade: _____
Emergency Contacts: (Name and Phone#'s):_____
_____

I. Parental/GuardianConsentfor Delegate Administration of Epinephrine Auto Injector

I hereby acknowledge my understanding that if the procedures outlines in P.L. 2007, c.57 and "TRAINING PROTOCOLS FOR THE EMERGENCY ADMINISTRATION OF EPINEPHRINE " issued by the NJ Department of Education are followed, the school district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto injector containing epinephrine and the parent/guardian shall indemnify and hold harmless the school district and its employees or agents against any claims arising from the administration of a pre-filled single dose auto injector containing epinephrine to the student. The school nurse shall designate, in consultation with the Board of Education, additional employees of the school district to administer epinephrine via auto-injector to my child for anaphylaxis or possible anaphylaxis when the school nurse is not physically presents at the scene, as specified in P.L. 2007, c.57.

____ I approve having delegate(s) assigned for my child.I understand that a list of my student'sdelegates is availablefor review in the Nurse's office.

____ I decline delegate administration of epinephrine for my child.

_____

Parent/Guardian Name Signature Date

II.Parental/Guardian Consent for Student Self Administration of Epinephrine Auto Injector and Antihistamine:

____I request that my child be ALLOWED to carry the prescribed medication for self-administration in school and on off-site school related activities pursuant to N.J.S.A.:18A:40-12.3-12.6. I give permission for my child to self-administer medication, as prescribed on this form for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

____I do not allow my child to carry and self-administer epinephrine auto injector and antihistamine

_____

Parent/Guardian Name Signature Date

III. Healthcare Provider's Order: (please check all applicable lines)

The above student has a potentially life threatening allergy that could result in anaphylaxis and
The Student's potential triggers of Anaphylaxis are: _____
The Student is an Asthmatic _____Yes _____No
The Student's possible symptoms of Anaphylaxis are: _____
Or _____possible symptoms are unknown at this time but student is at risk for future anaphylaxis.
The Student should sit at an Allergen Free Lunch Table: _____Yes _____No

In case of possible anaphylaxis administer: (Please DONOT prescribe TwinJet® products for school use)
____EpiPen® 0.3mgup to 2 doses as needed ____EpiPenJr® 0.15mg up to 2 doses as needed
*Please note our school standing orders allows a nurse to administer an equivalent dose of epinephrine via ampule and syringe

____**School nurse** may administer a single oral doseof Diphenhydramine: _____mg

____**Student**may self-administerepinephrine auto-injector as prescribed above. This student has been instructed in and is capable of proper method of self-administration of epinephrine auto-injector. This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____**Student**may self-administer a single oral doseof Diphenhydramine: _____mg

____This student is **not** approved to self-medicate with an epinephrine auto-injector or Oral Diphenhydramine

_____

Physician's Name Signature Date

Physician's Office Stamp:

Approved by School Nurse (signature and date): _____

Approved by School MD (signature and date): _____

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SCHOOL NURSE AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND OTC MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

The following section is to be completed by the PARENT/GUARDIAN:

_____

Student's Name DOB Grade

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_____ _____ _____

Parent/Guardian Signature Telephone Date

The following section is to be completed by the Medical Provider:

Name of medication: _____ Indication_____

Dosage: _____ Route: _____Administration Time: _____

If medicine is be given "PRN", describe indications: _____

When can the "PRN" medicine be repeated? _____

****PLEASE CHECK THE APPROPRIATE OPTION WHEN A PARENT/NURSE IS UNABLE TO ATTEND A CLASS TRIP**

_____ The prescribed dose can be withheld on the day of the class trip.
_____ The time to be given can be adjusted with the parent/guardian.

_____

Physician's Name Signature Date

Office Stamp:

This form must be individually completed for **all medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy or in the original box if an OTC medication.
All medications **will be kept** in a locked storage area.
It **may not** be possible to administer daily medication on half session days, early dismissal days or delayed opening days at the prescribed time. Parent/guardian will be notified if the medication could not be given to the student.
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