



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: _____

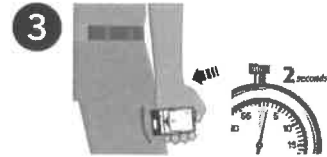
Antihistamine Dose: _____

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



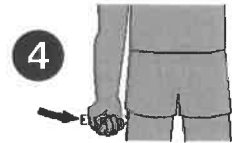
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



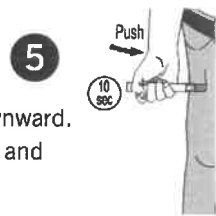
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

Date:

To: Parents/Guardians:

Re: 2022-2023 Food Allergy & Anaphylaxis Emergency Care Plan

Please download, review, and sign the FARE (Food Allergy & Anaphylaxis Emergency Care Plan) form at <http://www.foodallergy.org/file/emergency-care-plan.pdf>. Please complete the entire form, obtain required signatures, and return to your child's school.

The FARE form addresses:

- **Severe Symptoms**
- **Mild Symptoms**
- **Medication/Doses**
- **Directions – EpiPen Auto Injector**
- **Directions – Adrenaclick**
- **Directions – AUVI-Q**

In addition, please sign and return this memo along with the FARE form (which requires parent and physician signatures).

As per parent/guardian of the student listed below, I understand that if the procedures as specified in N.J.S.A. 18A:40-12.6 are followed, the district or non public school shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district, non public school, and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.

Student's Name: _____ **School:** _____

Physician Signature: _____ Date _____ Phone: _____

Parent/Guardian Signature: _____ Date _____ Phone: _____

Thank you

2022-2023 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL.

.....
NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER

**PERMISSION TO SHARE INFORMATION
2022-2023**

As you are aware, everyday each of our students has contact with a variety of staff members; teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include; known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.**

_____ **No, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.**

Parent/Guardian Signature

Date



90 Whippany Rd, Whippany, NJ, 07981

Health Office

Phone: 973-888-2083

MEDICATION PROTOCOL

Medication will be given in school only when a pupil's health and continuing attendance in school requires it and it is administered in accordance with the medication policy. No student is to carry medication to and from school. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.
2. A Mandatory Medication Form, Asthma Action Plan and/or Allergy Emergency Treatment form must be completed by the primary care provider and signed by parent/guardian.
3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider
4. Parents must bring all medications to the Health Office. Students should never carry medication to school unless the doctor specifically orders that the student may carry and self-administer emergency epinephrine or inhaler.
5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures on the form.
6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.
7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.
8. No parent's or primary care provider's phone instructions can be accepted.
9. Parents must pick up the medication from the Nurse in June on the last day of school. No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.



Allergic Reaction - Student Health History

Date: _____

Student: _____ **Grade:** _____ **Date of Birth:** _____

Allergen: _____

Students with life threatening allergies need to submit this completed form, a current allergy action plan (F.A.R.E) completed by the child's physician, and the prescribed medication to the school nurse.

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

2. **History and Current Status**

<p>a. What is your child allergic to?</p> <p><input type="checkbox"/> Peanuts</p> <p><input type="checkbox"/> Tree nuts (walnuts, pecans, etc)</p> <p><input type="checkbox"/> Eggs</p> <p><input type="checkbox"/> Milk</p> <p><input type="checkbox"/> Soy</p> <p><input type="checkbox"/> Fish/Shellfish</p> <p><input type="checkbox"/> Latex</p> <p><input type="checkbox"/> Insect Stings</p> <p><input type="checkbox"/> Other: _____</p>	<p>b. Age of student when allergy first discovered: _____</p> <p>c. How many times has student had a reaction? _____ Never _____ Once _____ More than once, explain: _____</p> <p>d. Explain their past reactions: _____ _____</p> <p>e. Symptoms: _____</p> <p>f. Are the food allergy reactions: _____ Same _____ Better _____ Worse</p>
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3. **Initial Allergic Reaction**

a. Date of First reaction: _____									
b. Reaction occurred from: _____ Ingestion _____ Contact _____ Sting									
c. For each allergen - List all symptoms/problems your child had, such as full body hives, swelling of face, difficulty breathing, diarrhea, vomiting, etc...									
d. Did your child go to the Emergency Room or doctor's office for this reaction? _____ No _____ Yes What treatment was given? _____ Did the health care provider prescribe medication to be given for future exposure to allergen? _____ No _____ Yes Medication name: _____									
e. Has your child had additional reactions to the allergen listed above? _____ No _____ Yes									
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 30%;">Date</th> <th style="width: 30%;">Reaction</th> <th style="width: 40%;">Treatment</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"> </td> <td> </td> <td> </td> </tr> <tr> <td style="height: 30px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Date	Reaction	Treatment						
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4. a. If your child ***did not*** have any reactions before being diagnosed with an allergy, was your child's allergy diagnosed by: _____ blood work _____ skin test

b. Did the physician prescribe medication to be given for future exposure to allergen? _____ No _____ Yes

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

c. 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 (lip, tongue, mouth)
Abdominal: _____Nausea _____Cramps _____Vomiting _____Diarrhea
Throat: _____Itching _____Tightness _____Hoarseness _____Cough
Lungs: _____Shortness of breath
Heart: _____Weak pulse _____Loss of consciousness

6. 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 the physician 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:

7. 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. Tell peers and adults about the allergy _____No _____Yes
 6. 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

8. Does your child have asthma? _____No _____Yes

All medications must be brought in by a parent and kept in the health office unless approval has been given by the student's physician for a student to carry medication with him/her. If your child has permission to carry an epinephrine auto-injector with him/her, please send an extra to be kept in the health office in the event your child forgets to bring it to school. All medication forms (including allergy and asthma forms) are required to be updated and resubmitted each school year at the beginning of the year. Failure to do so may compromise our ability to safely care for your child. If you have any questions, please contact the school Health Office.

Parent/Guardian Signature: _____ Date: _____



The Arrow Academy
Health Office

90 Whippany Rd, Whippany, NJ 07981
Phone: 973-888-2083

Emergency Administration of Epinephrine

PARENT'S / GUARDIAN'S AUTHORIZATION

Student's Name: _____ **Grade:** _____

Allergic Condition: _____ **Date of Birth:** _____

I consent to the following for the 20__/20__ school year:

1. I give permission for my child, named above, to receive emergency administration of epinephrine at school as prescribed by my child's physician.
2. In the event that our child experiences potentially life-threatening symptoms related to his/her allergic condition as described by his/her physician, we authorize the emergency administration of epinephrine by a pre-filled auto-injector by the school nurse and in her absence by a registered nurse or an employee who is properly trained in the administration of epinephrine auto-injection and is designated by the school nurse in consultation with The Arrow Academy Building Administrator.
3. The school nurse, in consultation with The Arrow Academy Building Administrator, may designate another employee of the non-public school to administer epinephrine by a pre-filled single dose auto-injector when the school nurse is not physically present at the scene. The employee(s) will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.
4. We acknowledge our understanding that if the procedures for the emergency administration of epinephrine are followed, The Arrow Academy non-public school, collectively and individually, as well as its employees and agents, shall have no liability as a result of any injury arising from the administration of epinephrine to our child.
5. We indemnify and hold harmless The Arrow Academy non-public school, collectively and individually, as well as its employees and agents against any claims arising out of the emergency administration of epinephrine to our child.
6. We understand that our child will be transported to the hospital Emergency Room after the administration of epinephrine even if the child's symptoms have resolved.
7. I give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medication.
8. I give permission for the school nurse to share pertinent medical information with members of The Arrow Academy staff who have direct responsibility for my child during school or at a school sponsored event. This consent is only valid for this school year.
9. I will assure that the medication is in its original prescription container.
10. I understand that it is my responsibility to ensure that the student has the medication available at school at all times.
11. I will be responsible for noting the expiration date and replacing expired medication.
12. I will contact the school nurse with any questions or changes in my child's health condition.

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