ARROWACADEMY
MARKED WITH PURPOSE

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**

a. What is your child allergic to?
- ☐ Peanuts
- ☐ Tree nuts (walnuts, pecans, etc)
- ☐ Eggs
- ☐ Milk
- ☐ Soy
- ☐ Fish/Shellfish
- ☐ Latex
- ☐ Insect Stings
- ☐ Other:_____

b. Age of student when allergy first discovered:_____
c. How many times has student had a reaction?
_____Never _____Once _____More then once, explain:
_____
_____
d. Explain their past reactions:_____
_____
_____
e. Symptoms:_____
_____
f. Are the food allergy reactions:
_____Same _____Better _____Worse

3. **Initial Allergic Reaction**

a. **Date of First reaction:** b. **Date of Last reaction:**

c. Reaction occurred from: _____Ingestion _____Contact _____Sting

d. **For each allergen** - List all symptoms/problems your child had, such as full body hives, swelling of face, difficulty breathing, diarrhea, vomiting, etc…

e. 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:_____

f. Has your child had additional reactions to the allergen listed above? _____No _____Yes

Date	Reaction	Treatment

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 _____Diarreha
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: _____

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

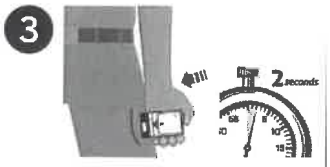
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

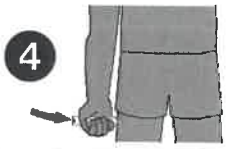
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



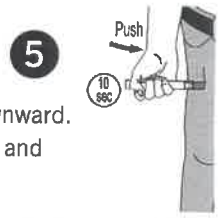
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

Date:

To: Parents/Guardians:

Re: 2024-2025 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:_____ Phone: _____
Date

Parent/Guardian Signature:_____ Phone: _____
Date

Thank you

Rev: 9/22/16

2024-2025 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 _____ (DATE) TO _____ (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
2024-2025

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

2024-2025 PHYSICIAN/PARENT CERTIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

TIME AND CIRCUMSTANCES OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

I certify that _____ has a potentially life threatening illness
(Student)
which requires the use of _____. I further certify that
(Medication)
_____ is capable and has been instructed in the proper method of
(Student)
self-administration of _____
(Medication)

_____ _____
Signature of Physician Date

PHYSICIAN NAME: _____ TELEPHONE #: _____

****

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter _____ to self-administer (Name of Medication) _____ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-administration of medication by (student name) _____.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising out of the self-administration of (medication) _____ by (student name) _____.

_____ _____
Parent/Guardian Signature Date

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially life threatening illness is allowed under guidelines established by the school and provided that the statutory requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY A STUDENT.

Rev: 4/2015

PLEASE SIGN & RETURN

ARROWACADEMY
MARKED WITH PURPOSE

Health Office
90 Whippany Rd, Whippany, NJ 07981
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:** _____

ARROWACADEMY
MARKED WITH PURPOSE
Health Office
90 Whippany Rd, Whippany, NJ, 07981
(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.

ARROWACADEMY
MARKED WITH PURPOSE

Health Office
90 Whippany Rd
43 South Jefferson Rd
Whippany, NJ 07981
973-888-2083

Safe Snacks

Date:_____

Dear Parent/Guardian of _____:

Our medical records indicate that your child has an allergy or medical concern that may be affected by certain foods. To ensure a safe environment for your child, we kindly ask that you supply 3-5 single-serve snacks for your child. These snacks will be labeled with your child's name and kept in their classroom for any occasion when your child may need a snack. This could be on days when an additional snack is needed or during classroom celebrations when a food item has not been pre-approved. Providing these approved snacks will help us ensure your child's safety.

If you feel that your child does not need a safe snack and is allowed to eat food items provided at Arrow Academy, please complete the bottom slip and return to the health office.

Please contact me with any questions or concerns.

Thank you for your understanding in this matter,

Susan Peluso RN
School Nurse
susan@thearrowacademy.org

Date:_____ Grade:_____

Student Name:_____

☐ I do not feel that my child needs a supply of safe snacks kept in school. I give permission for my child to eat any food provided at Arrow Academy.

☐ I will supply safe snacks in school for my child. This will help provide him/her a safe environment during special events/parties and/or in cases where he/she may need an extra snack.

Parent/Guardian Signature:_____