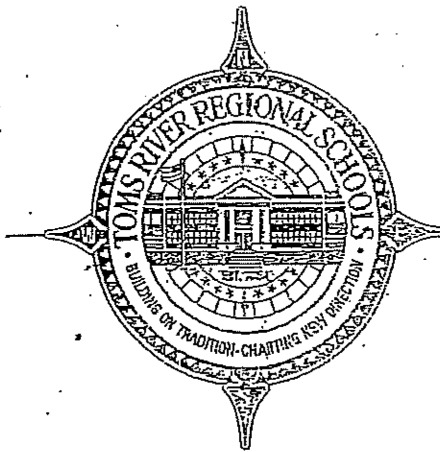


TOMS RIVER REGIONAL SCHOOLS

FOOD ALLERGY/ALLERGIES

You have indicated to us that your Child________________________ Grade _______

Date of birth____________________________ has food allergy/allergies

to: ____

- What type of reaction does your child experience? Please be specific and describe the exact reaction. ____
- When was your child's last reaction? _________________________________
- Does your child experience a reaction by being **around or near** the food he/she is allergic to? ____
- Has your child ever required medication for this allergic reaction? If YES, please list medication used. Have your child's doctor complete the Emergency Action Plan and Permission to Medicate forms and return to us as soon as possible.
- Will your child need **special accommodations** regarding food during classroom activities, holiday parties, snacks, field trips, etc.?______________________

___ Please **DO NOT** permit my child to have any foods except those provided by me.

____ I allow my child to participate in any class or school activity. I understand that there is the possibility that some foods in the classroom or lunchroom may contain ingredients that my child is allergic to. The school staff has been informed of my child's allergies but cannot guarantee that he/she will not ingest something that they may react to. I am permitting my child to have classroom snacks as well as purchase foods from the lunchroom.

Other accommodations: ____

________________________________ ____________________
Parent signature Date

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________________ D.O.B.: ______________

Allergy to: ______________________________

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

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: ______________

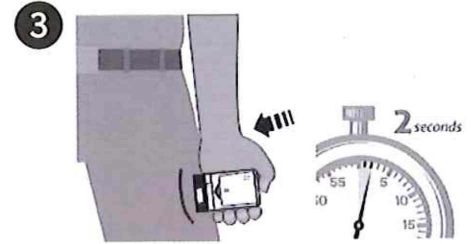
Other (e.g., inhaler-bronchodilator if wheezing): ______________

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

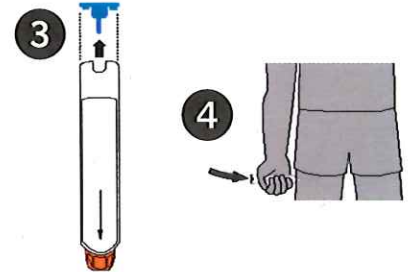
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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



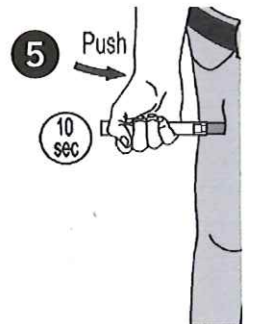
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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



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

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



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: ____________________

TOMS RIVER BOARD OF EDUCATION

Dear Parent/Guardian:

Re: N.J.S.A. 18A:40-12.5 and 12.6 **Development of policy for emergency administration of epinephrine via pre-filled auto-injector mechanism to pupil.**

The board of education shall develop a policy in accordance with the guidelines established by the Department of Education pursuant to section 4 of P.L. 2007, c.57 (C.18A:40-12.6a) for the emergency administration of epinephrine via pre-filled auto-injector mechanism to a pupil for anaphylaxis provided that:

a) The parents or guardian of the pupil provided to the board of education written authorization for the administration of the epinephrine;

b) The parents or guardian of the pupil provide to the board of education written orders from the physician or advanced practice nurse that the pupil required the administration of epinephrine for anaphylaxis *and does/ does not (please circle) have the capability for self-administration of the medication;*

c) The board informs the parents or guardians of the pupil in writing that the district and its employees or agents shall have no liability as a result of any injury arising from the administration of the epinephrine via pre-filled auto-injector mechanism;

d) The parents or guardians of the pupil sign a statement acknowledging their understanding that if the procedures specified in this section are followed, the district 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 and its employees or agents or the non-public school and its employees or agents against any claims arising out of the administration of the administration of the epinephrine via a pre-filled auto-injector mechanism;

e) The permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements in subsections a. through d. of this section.

If you desire the above mentioned district policy provisions available to your student for this school year, please complete and sign all enclosed pages of this form and return immediately to the school nurse.

Sincerely,

__________________R.N.

I have read and acknowledge the above.

Parent Signature __________________________________

AUTHORIZATION FOR EMERGENCY ADMINISTRATION

OF EPI-PEN BY A DESIGNATED INDIVIDUAL

Date: ______________________

I hereby authorized the Toms River Board of Education to designate a nurse, or in her absence, a trained designee, to administer the Epi-pen to my child ____ in case of an emergency.
(Name of child, please print)

Attached please find the written orders from Dr. ____________________, my child's physician, stating that my child required the administration of epinephrine for anaphylaxis and that he/she **does/ does not (please circle) have the ability to self-medicate.**

I understand that if the procedures specified in the NJSA 18A:40-12.5 are followed that the district shall have no liability, as a result of any injury arising from the administration of a pre-filled, single dose, auto-injector mechanism containing epinephrine to the pupil and I shall indemnify and hold harmless the district and its employees.

______________________________	______________________________	____________
Parent/Guardian Name (print)	Parent/Guardian, Signature	Date

TOMS RIVER REGIONAL SCHOOLS

Dear Parent/Guardian of:

You have informed me that your child has an allergy to **NUTS**. In order to provide a safe environment in the cafeteria, please check one of the following statements and return to my office with your child's attached emergency care plan and medication in September.

Your child will be assigned to the Peanut / Tree nut free table during the lunch period unless otherwise stated on this form.

Please feel free to call me with any questions/concerns.

Thank You,

School Nurse

________ My Child should be seated at the Peanut / Tree nut free table in the cafeteria for the

________ school year.

_________ My child does **NOT** need to be seated at the Peanut / Tree nut free table for the

__________ school year.

Child's Name: ____

Parent/Guardian Name: ______________________________________

Parent/Guardian Signature: ___________________________________

Date: ________________________________

SELF MEDICATION PERMISSION FORM

In accordance with Chapter 308, P.L. 1993, this form must be signed by the parents or guardians of any student who wishes to self-administer medication. Please complete **Asthma Treatment Plan** for inhalers.

We ____________________________ and ________________________ **(Print names of parents)** are the parents or guardians of ___________________________ **(Print name of student)** ___________ **(Grade)** a student in the Toms River Regional Schools. As required by law, this form provides to the Toms River Board of Education our written authorization for our child to self-administer medication. We further acknowledge, that by copy of this form, the Toms River School Board has informed us that the district, it's employees or agents, shall incur no liability as a result of any injury from the self-administration of medication by our child and we expressly agree to defend, protect, indemnify, and hold harmless the Toms River School District, and it's employees or agents, from all losses, costs, suits or claims which may result from the self-administration of medication by our child.

This form is the written certification of our physician verifying the diagnosis of my child as potentially life-threatening and the provision of medication instructions. Permission for our child to self-administer medication is effective upon approval and notification by the Toms River Regional School Board. Permission remains effective only for the present school year.

____________________________________ ____________________

Signature of Parent/Guardian Date

PHYSICIAN CERTIFICATION FOR SELF MEDICATION BY STUDENT

In accordance with Chapter 308, P.L. 1993, I ________________________ **(Print name of Physician)** certify that I am the Physician of ________________________ **(Print student's name).** This patent suffers from ______________________ **(Print name of illness),** potentially life-threatening illness, and is capable of, and has been instructed in, the proper method of self-administration of medication / and or a

Name of Medication: ____

Dose/Route: ___________________________ Time: _________________

Known Allergies:_______________________ Date:__________________

Signature of Physician: _____________________ Physician Stamp:

Please return this form to the Nurses Office

Revised 3/07, 5/07, 4/09, 9/2016