PUBLIC SCHOOLS OF
Pemberton Township

One Egbert Street, Pemberton, NJ 08068
Phone: 609-893-8141

Mike Gorman, Superintendent
Heidi Bouchard, Supervisor of Athletics

Date:_____

Dear Parent/Guardian,

Our school health records indicate that your child, _____, has doctor's orders for an Epi-Pen in order to prevent severe allergic reactions that may lead to Anaphylaxis – a potentially life threatening allergic reaction.

State Law 18A:40-12.6 gives permission for the school nurse to train an Epi-pen Delegate in case a school nurse is not immediately available or your child is unable to administer the medication themselves.

If your child is involved in any after school activities, including attending dances, I am requesting that you and your child's physician fill out the attached paperwork so that we can train and assign a delegate to your child in case of an emergency. The chances of your child ever needing a delegate is very slim, however, we want to be prepared in case of an emergency so that we can save your child's life if the need arises.

Since the school nurse will not be available, it is important that you provide permission for the emergency administration of the epi-pen by a designee in accordance with NJSA 18A:40-12.6. If you are unwilling to allow the school to train and assign a delegate, then your child will not be allowed to participate in after school clubs or activities because we can not guarantee his/her safety.

Please feel free to contact me at (609)893-8141 ext 2022 or your school nurse (Newcomb – ext. 3505, Helen Fort – ext. 3011) if you have any questions regarding epi-pen delegation training. Thank you in advance for working with us to insure your child's health and safety.

Sincerely,
Heidi Bouchard
Supervisor of Athletics, Health/PE K-12, Nurses K-12

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Delegation of Epinephrine

(Permission to train qualified school personnel to administer epinephrine in the absence of the school nurse)

I acknowledge that my child_____has a history of an allergic reaction; which may lead to anaphylaxis; a rapid, severe, life threatening allergic reaction to_____
as documented by Dr._____.

In accordance with State Law 18A:40-12.5, I give permission for the school nurse to delegate the administration of epinephrine to my child when the school nurse is not immediately available. A copy of my child's Anaphylaxis Individual Emergency Care Plan will be shared with the delegate(s).

If you choose not to allow the school to train and assign a delegate, then your child will not be allowed to participate in after school clubs or activities when a school nurse may not be present.

I understand 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 a pre-filled auto-injector mechanism; and shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of the epinephrine via a pre-filled auto-injector mechanism.

State law mandates that once epinephrine has been administered the student must be transported to a hospital by emergency services personnel.

Signature of Parent/Guardian_____Date_____

Signature of School Nurse_____

Anaphylaxis Individual Emergency Care Plan – Pemberton Township Public Schools

Name: _____ D.O.B.: _____

Allergy to: _____

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

Does student have a documented incident of anaphylaxis? ☐ Yes ☐ No

Extremely reactive to the following: _____

Therefore:

☐ Give epinephrine immediately for **ANY** symptoms if there was a likely exposure.

☐ Give epinephrine immediately if there was exposure to the allergen, **even if no symptoms are noted.**

Otherwise:

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confuse
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box on back page)
4. Give additional medications.* (If ordered)
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

→

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professional and parent
3. Dismiss student to care of parent or guardian
4. If symptoms progress (see above), USE EPINEPHRINE

Medication/Doses:

Epinephrine: ☐ 0.15mg **or** ☐ 0.3mg ☐ May repeat dose in 15 minutes if symptoms continue.

Antihistamine: _____

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

*Please note that by NJ state law only the administration of epinephrine can be delegated to non-nursing school staff.

Self-Administration:

☐ I have instructed the above student in the proper administration of epinephrine/antihistamine. It is my opinion that he/she is capable of self-administration. Student must notify teacher or School Nurse when he/she has administered epinephrine/antihistamine.

OR

☐ It is my opinion that the above student **is not** capable of self-administration.

Contacts: Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contact: _____ Phone: _____

Doctor's Office Stamp

_____ _____

Parent/Guardian Signature Date

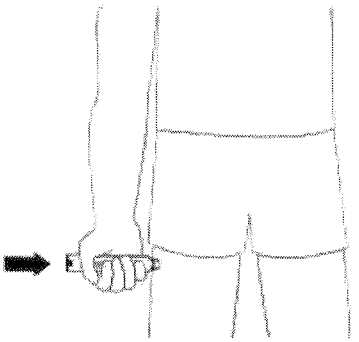
_____ _____

Healthcare Provider Signature Date

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

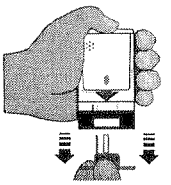
EpiPen 2-Pak® EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

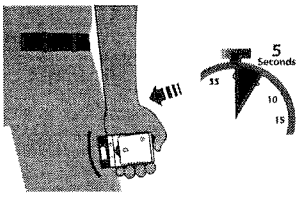
EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty L.P.

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.





Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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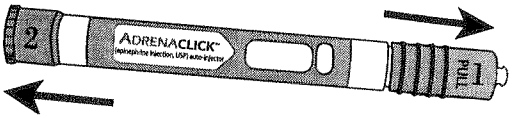
Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Monitoring

Stay with student; alert healthcare professionals and parent. Note time when epinephrine was administered and tell EMS. Give used epinephrine auto-injector to EMS for safe disposal. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See above for auto-injection technique.

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Combivent® ☐ Maxair® ☐ Xopenex®	2 puffs every 4 hours as needed
☐ Ventolin® ☐ Pro-Air® ☐ Proventil®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Combivent® ☐ Maxair® ☐ Xopenex®	2 puffs every 20 minutes
☐ Ventolin® ☐ Pro-Air® ☐ Proventil®	2 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❑ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❑ Foods:
  - ❍ _____
  - ❍ _____
  - ❍ _____
- ❑ Other:
  - ❍ _____
  - ❍ _____
  - ❍ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

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REVISED AUGUST 2013

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Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. 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** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"

PACNJ approved Plan available at www.pacnj.org

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