



EASTERN CHRISTIAN
SCHOOL

Dear Parent/Guardian:

If it is necessary for your child to receive Epinephrine during school hours, school health policy requires that you provide a written request for the administration of the prescribed medication. On a separate page, you will find the “Administration of Epinephrine” policy of Eastern Christian School Association. Your private physician must complete the “**Food Allergy & Anaphylaxis Emergency Care Plan**” form. There is also a “**Self-Administration**” form which needs to be filled out by the physician and “**Medication Contract**” form to be signed by both student and parent/guardian. These forms must be submitted each school year.

The school nurse or parent/guardian is the only one permitted to administer medication in the school. In the event that the school nurse is not present, the parent can give written authorization for a delegate to administer epinephrine via auto-injector. We have an “**Acknowledgement**” form that can be obtained from the school nurse at the campus your child will be attending, and signed by the parent/guardian. Only the school nurse, acting on physicians’ orders, may give Benadryl first, observe for further symptoms, assess according to the best nursing practice, and follow with epinephrine as necessary. In the absence of the school nurse, the delegate, who has been properly trained according to standardized training protocols, will immediately give the epinephrine auto-injector. The nurse will review in advance the administration procedure with the delegate.

Please review the policy and return the completed forms. Also, please provide a current pre-filled single dose auto-injector mechanism containing epinephrine in the original box with prescription label from the pharmacy attached. The epinephrine will be kept in a secure but unlocked location easily accessible by the school nurse and delegates.

Any questions, please feel free to contact us at the appropriate school. The telephone number for the Elementary School is 201-445-6150; the Middle School is 201-891-3663; and the High School is 973-427-0900.

Thank you,

ECSA School Nurses

**PLACE
PICTURE
HERE**

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: _____

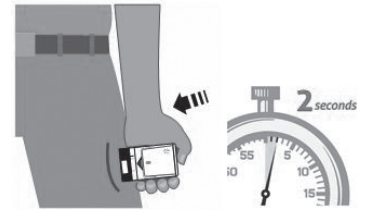
Antihistamine Dose: _____

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

HOW TO USE AUVI-Q® (EPINEPHRINE 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.

3



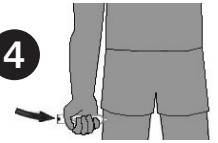
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.

3



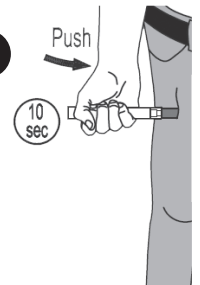
4



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.

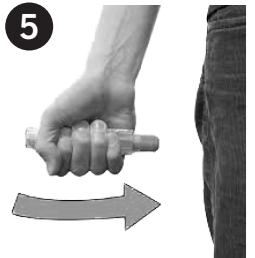
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HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

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.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5



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: _____



EASTERN CHRISTIAN
SCHOOL

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Request for Self-Administration of Prescription Medication

To be completed by Physician (please print)

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

OTHER MEDICATIONS USED AT HOME: _____

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

Conditions under which self-administration will take place:

____ Under Supervision of School Nurse (or designated personnel)

____ Independently (**child has been trained**)

Medication should be:

____ Stored in Nurse's office ____ In possession of student

Physician's Name (print)

Date

Physician's Signature

Phone

*******Other side must be filled out and signed by student and parent*******



EASTERN CHRISTIAN
SCHOOL

MEDICATION CONTRACT

Date _____

Student Name _____

Grade _____

Medication _____

I understand that I will use this medication as directed by my physician. I will be responsible and discreet in using this medication and should have this medication **readily available**.

I have been instructed how to self-administer this medication and understand the side effects of improper use. This medication must be carried in the original labeled pharmacy container.

I will not share this medication with anyone else.

I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication.

Student's Signature

Date

To be completed by parent:

I give permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or if the physician no longer directs self-administration. The medication is to be provided by me in the original, labeled container. To my knowledge, my child is not allergic to this medication. I hereby release Eastern Christian School Association and its employees from any liability for injuries or other damages which may result to the student from administration of this medication. Eastern Christian is released from any liability should the student share this medication with another student.

Parent's/Guardian's Signature

Date

It is the policy of Eastern Christian School Association to apply New Jersey Public Law 2007, Chapter 57 in the following way:

The school will provide for the administration of epinephrine auto injection for certain students.

The school nurse or trained designated individual(s) are able to administer epinephrine in accordance with New Jersey Public Law 2007, Chapter 57. This may be facilitated as follows:

- The parent or guardian of the student has provided his/her written authorization for the administration and/or permits the self-administration of the epinephrine;
- The parent or guardian of the student has provided written orders from the primary health care provider that the student requires the administration of epinephrine and that a nurse or a trained designated individual(s) may administer the treatment, and/or the student has been instructed in and is capable of self-administration of epinephrine as certified in writing by their physician;
- The parent or guardian signs a statement acknowledging that all individuals involved shall have no liability as a result of any injury arising from the administration of the epinephrine and that the parent or guardian shall indemnify and hold harmless the individuals involved against any claims arising out of the administration of the epinephrine by a designee or by the student's self-administration;
- The parent or guardian has read this school policy on the administration of epinephrine and has signed the epinephrine acknowledgement form indicating his/her understanding and acceptance of the policy;
- It is the responsibility of the parent/guardian to provide a current pre-filled single dose auto-injector mechanism containing epinephrine in original box with prescription label from pharmacy attached; the epinephrine will be kept in a secure but unlocked location easily accessible by the school nurse and designees;
- The parent/guardian is responsible for replacing the pre-filled, single dose auto-injector mechanism containing epinephrine when it has expired and/or it has been used;
- Orders must be renewed yearly.

The school nurse or the designated individual(s) will be promptly available onsite at the school and school sponsored functions if a situation arises where a student experiences a severe allergic reaction/anaphylaxis. (911) will also immediately be called and the student will be transported to a medical health care facility after the administration of epinephrine, even if the student's symptoms appear to have resolved. Under no circumstances will epinephrine be administered if there is no order from a primary health care provider.



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To be completed by Parent/Guardian:

I give my permission to the school nurse, or other unlicensed assistive personnel (UAP) educated by the nurse, to administer the medication/procedure listed below to my child during regular school hours and at other times when my child is participating in a school related event. I hereby release Eastern Christian School Association and its employees from any liability for injuries or other damages which may result to the student from administration of this medication/procedure.

The medication is to be furnished by me and is to be Pharmacy labeled with the name of the medicine, the amount to be given, time of day to be taken.

Parent's/Guardian's Name (please print): _____

Signature _____ Date _____
(Parent/Guardian)

To be completed by Prescribing Health Care Provider:

NAME OF CHILD: _____ GRADE: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

MEDICATION TO BE ADMINISTERED FOR THE PERIOD FROM _____ TO _____
(Date) (Date)

DOSAGE: _____

FREQUENCY & DIRECTIONS: _____

DESCRIPTION OF PROCEDURE: _____

PURPOSE OF DRUG/PROCEDURE: _____

POSSIBLE SIDE EFFECTS: _____

APPROPRIATE FOR DELEGATION TO UNLICENSED ASSISTIVE PERSONNEL _____ YES _____ NO

Signature: _____ Date: _____
(Health Care Provider)

Address: _____ Telephone: _____
