PARENT LETTER RE: SELF ADMINISTRATION OF EPINEPHRINE FOR A POTENTIALLY LIFE THREATENING ILLNESS

The Sussex County Charter School for Technology Board of Trustees will permit the self-administration of Epinephrine via auto-injector by a student for a potentially life threatening illness provided that:

- The parents or legal guardian of the student provide the Superintendent and the School Nurse written authorization from the healthcare provider for the self-administration of Epinephrine via auto-injector.

- The parents or legal guardian of the student provide the Superintendent and the School Nurse written certification from the healthcare provider that the student has a potentially life threatening illness and has been trained in the proper method of and is competent to self-administer the Epinephrine via auto-injector.

- The parents or legal guardian of the student sign a statement acknowledging the school shall incur no liability as a result of any injury arising from the self-administration of the Epinephrine via auto-injector by the student and the parents or legal guardian shall indemnify and hold harmless the school, the Board of Trustees & its employees or agents from any and all claims arising out of the self-administration of this medication.

- The permission is effective for the school year in which it is granted and must be renewed for each subsequent school year.

For your convenience, a form to be completed by your healthcare provider and you is attached; should you have any questions, please feel free to contact your child's School Nurse.

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EPINEPHRINE SELF MEDICATION FORM

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

STUDENT NAME: _____DATE OF BIRTH_____

I am prescribing the following medication for the above named student and recommend this student be allowed to self-administer Epinephrine via auto-injector for an anaphylactic reaction due to an allergy to nuts, etc. I hereby certify that my patient may require the administration of Epinephrine while attending school or school related functions. This student would not be able to attend school if the medication cannot be administered during school hours. He/she is free of contagious disease and physically fit to attend school.

Potentially life threatening condition:

Name of medication:

Dosage:

Condition under which medication is to be used:

Length of time medication is to be used:

Potential side effects:

List other medications student receives that might enhance, alter or impact the effects of this medication:

This student has been instructed in the proper method of self-administration of Epinephrine via auto-injector and in my professional opinion is competent to self-administer the prescribed medication.

Medication may be kept in the students' possession.

Healthcare Provider's Name (print) _____

Healthcare Provider's Signature/Title_____

Telephone Number_____Date_____

PAGE TWO TO BE COMPLETED BY A PARENT OR GUARDIAN
TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

I give permission for my child to self-administer the Epinephrine via auto-injector as prescribed. I understand the **Sussex County Charter School for Technology** shall incur no liability as a result of any injury arising from the self-administration of the medication by my child and I shall indemnify and hold harmless the school, the Board of Trustees and its employees or agents from any and all claims arising out of the self-administration of this prescribed medication.

It is further understood that my child will secure this medication in such a manner that it will not be available to other students. My child will report any administration of this medication to the School Nurse; telling a teacher, coach or an individual in charge if the School Nurse is unavailable.

_____	_____
Parent/Guardian's Name (print)	Parent/Guardian's Signature
_____	_____
Cell Phone Number	Date
_____	_____
Work Phone Number	
_____	_____
Superintendent's Signature	Nurse's Signature

TO BE COMPLETED BY A PARENT OR GUARDIAN

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)