LIVINGSTON SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name _____Birth date _____ Grade/teacher_____

The above student is allergic to: _____

Previous episode of anaphylaxis [] Yes [] No

MEDICATIONS

ANTIHISTAMINE: Name _____Dose_____

Give antihistamine for the following checked symptoms:

[] Contact with allergen, but no symptoms
[] Skin – hives, itchy rash, extremity swelling
[] Lips – itching, tingling, burning, or swelling of lips
[] Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
[] Gut – abdominal cramps, nausea, vomiting, diarrhea
[] Lungs- repetitive cough, wheezing, shortness of breath
[] Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
[] Other _____

EPINEPHRINE: [] EpiPen [] EpiPen Jr. [] Other _____

Give epinephrine for the following checked symptoms:

[] Contact with allergen, but no symptoms
[] Skin – hives, itchy rash, extremity swelling
[] Lips – itching, tingling, burning, or swelling of lips
[] Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
[] Gut – abdominal cramps, nausea, vomiting, diarrhea
[] Lungs- repetitive cough, wheezing, shortness of breath
[] Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
[] Other _____

Choose one administration order:
Give Antihistamine only [] Give Epinephrine only [] * Delegate will be assigned
Give Antihistamine & Epinephrine at the same time []
Give Antihistamine first, observe for further symptoms and give Epinephrine PRN []

*** Please note: In the absence of the school nurse, any antihistamine order will be disregarded and a trained delegate will give the auto-injectable dose of epinephrine.**

[] This student has been trained and is capable of self-administration of the following medication(s).
[] Epinephrine – single unit dose [] Antihistamine – single unit dose

[] This student is not capable of self-administration of the medications named above.

Physician's signature _____Phone number_____

Date _____ Stamp _____

PARENTS PLEASE COMPLETE REVERSE SIDE

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container.

Please sign and date

I verify that my child _____has a potentially life threatening illness. I hereby request the school nurse or delegate (If applicable) to administer the prescribed medication to my child. I further acknowledge that the Livingston Township School District incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Livingston School District Policy are followed, I shall indemnify and hold harmless the Livingston School District and its employees or agents against any claims arising out of administration of medications to my child.

_____ _____
Signature of Parent/Guardian Date

Please sign
I understand that under NJ state law, a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

_____ _____
Signature of Parent/Guardian Date

SCHOOL USE ONLY

_____ _____
Signature of Principal Date

_____ _____
Signature of School Nurse Date