

EpiPen Administration

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Dear Parent/Guardian:

As you will notice, the paperwork regarding EpiPen administration has changed. Please review the highlighted points listed below before you complete the forms.

1. The school nurse is responsible for administration of the EpiPen during school hours.
2. With physician approval, students still are permitted (and encouraged) to self-administer the EpiPen. The student should carry the EpiPen with him/her at all times.
3. If you choose to authorize the school nurse to designate and train one or more employee volunteers to administer the EpiPen in the event that the student is incapacitated and unable to self-administer and a school nurse is not available (after school), please be aware of how this will occur:
 - a. The student must provide a second EpiPen to the school nurse.
 - b. The second EpiPen, along with the individual emergency orders, will be placed in an individual medication pack.
 - c. Students will be made aware of the employee designees.
 - d. If an employee designee is available at an event, the student's individual medication pack and emergency orders will be accessible to the designee.
 - e. If there is no nurse or designee available, 911 will be activated in the event of an allergic reaction.

West Windsor-Plainsboro Regional School District

- (1) **PERMISSION TO ADMINISTER EPINEPHRINE VIA PRE-FILLED AUTO INJECTOR;**
(2) **PERMISSION OR REFUSAL TO APPOINT DESIGNEE**

- 1) Our child, _____, requires the administration of epinephrine in case of an anaphylactic reaction. We understand that we must submit to the School Nurse written orders from a healthcare provider, indicating that our child requires the administration of the medication. We further understand that we must provide the school with a current epinephrine pre-filled auto-injector, that we are responsible for replacing it when it has expired or been used, and that we shall pick it up at the end of the school year or the end of the period of administration. Our permission is effective for the school year for which it is granted. We understand that the School Nurse will be available during the regular school day but will not be available at school-sponsored events or after school activities in the event of an allergic reaction. The trained designee, if appointed, will be available during school hours and at school-sponsored events. We realize that it is our responsibility to inform the School Nurse in a timely manner of the school-sponsored events in which our child will participate. We further understand that the designees may be assigned to students who are qualified to self-administer their emergency medications, as well as to those who are not qualified to self-administer. In the event that we decline to have a designee appointed, we also understand that there will not be a nurse at school-sponsored events occurring outside the regular school day. Pursuant to N.J.S.A. 18A:40-12.5, we acknowledge our understanding that West Windsor-Plainsboro Regional School District, its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to our child, and we indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine to our child. **We hereby grant permission to the School Nurse to administer epinephrine via a pre-filled auto-injector mechanism, to treat our child for anaphylaxis.**

Parent/Guardian Signature

Date

- 2) We **authorize** the School Nurse to designate and train one or more employee volunteers of the West Windsor-Plainsboro Regional School District to administer epinephrine via pre-filled auto-injector mechanism to our child in case of emergency, when the School Nurse is not present. We understand that no other medications, such as antihistamines, may be administered by the designee, and that the epinephrine via pre-filled auto-injector mechanism will be administered by the designee according to the orders provided by our child's Healthcare Provider.

Parent/Guardian Signature

Date

- 3) We **DO NOT** authorize the School Nurse to designate one or more employees of the West Windsor-Plainsboro Regional School District to administer epinephrine via pre-filled auto-injector mechanism to our child. We understand that a nurse will not be available during school-sponsored events outside the standard school day and that 911 will be activated in the event of an allergic reaction.

Parent/Guardian Signature

Date

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT EMERGENCY ALLERGY ACTION PLAN & MEDICATION ADMINISTRATION FORM

Emergency Information for:

Name: _____ Grade: _____ School Year: _____

Life-Threatening allergies to: (Please list **any/all** known allergens)

Student has history of **documented** anaphylaxis: (circle one) **YES NO**

Student **is capable** of self-administration: (circle one) **YES NO**

Is student an asthmatic? (circle one) **YES NO**

Name: _____ D.O.B.: _____

Allergy to: _____

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

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Short of breath,
wheezing,
repetitive cough



HEART

Pale, blue,
faint, weak
pulse, dizzy



THROAT

Tight, hoarse,
trouble
breathing/
swallowing



MOUTH

Significant
swelling of the
tongue and/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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy/runny
nose,
sneezing



MOUTH

Itchy mouth



SKIN

A few hives,
mild itch



GUT

Mild nausea/
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: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

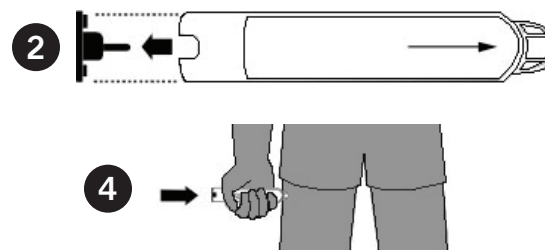
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

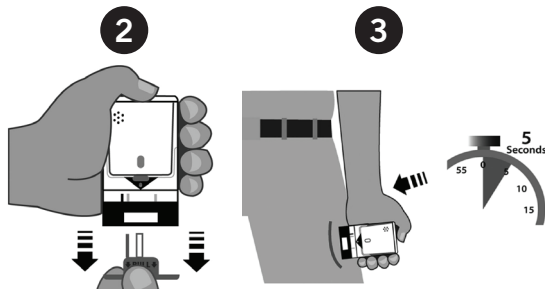
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENALCLICK®/ADRENALCLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT
RECOMMENDATION OF PRIVATE PHYSICIAN FOR
SCHOOL NURSE OR DESIGNEE
TO ADMINISTER EPINEPHRINE AUTO INJECTOR

Student's Name _____ **DOB** _____ **Grade** _____

TO BE COMPLETED BY PHYSICIAN: (PLEASE PRINT)

The above named student has an allergy to _____
and it will be necessary to administer the following medication in the event of an anaphylactic reaction. Since this
student is not capable of self-administration of the medication, I authorize the following medication to be administered by the
school nurse or a trained designee:

MEDICATION: _____ **DOSAGE:** _____ **ROUTE** _____

Date of Last Anaphylactic Reaction: _____

WHEN GIVEN (TIME AND/OR SYMPTOMS): _____

SYMPTOMS PREVIOUSLY EXPERIENCED: _____

KNOWN TRIGGERS: _____

HOW SOON CAN MEDICATION BE REPEATED? _____

SIDE EFFECTS/SPECIAL PRECAUTIONS: _____

MEDICATION SHOULD BE:

☐ Stored in Health Office or designated area ☐ In the possession of the student ☐ Other _____

Physician's Name (Print)

Physician's Signature

Telephone Number

Date

TO BE COMPLETED BY PARENT/GUARDIAN:

The above ordered 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 and hold harmless the Board, its agents, servants and employees from all
liability for injuries or other damages to the student, his/her servants and representatives that may result from
administration of the medication.

MY CHILD ATTENDS THE WEST WINDSOR-PLAINSBORO BOARD OF EDUCATION
EXTENDED DAY PROGRAM _____ YES _____ NO

PARENT/GUARDIAN'S SIGNATURE

DATE