MANASQUAN ELEMENTARY SCHOOL

Gina Melillo RN, School Nurse
168 Broad Street
Manasquan, NJ 08736
(732) 528-8810 ext.2007
fax: (732) 223-9736
gmelillo@manasquanboe.org

To: Parent/Guardian

From: School Nurse

RE: Medications in school

If your child's medical condition requires the administration of medication during school hours or during after school sports, then the information must be provided on the form that appears on the reverse side of this letter. (Please make copies as needed).

The form must be completed **and signed by you and your physician** and returned to the school nurse **with the medication in the pharmacy's labeled container**.

*Students living with **Diabetes** must provide this form for both the Insulin and Glucagon that the student carries.
*Students living with **Asthma** or exercise induced Asthma, must provide this form and have the appropriate area checked off by the Dr. in order to carry their own inhalers.
*Students at risk for **anaphylactic reaction**, due to bee stings or food allergies, must provide this form with Epinephrine injection.
*Students who need to take over the counter medication during school hours must also have their Dr. fill out this form for that medication to be given at school.

Failure to complete this form may delay the sports pre-participation process, especially if a delegate has to be trained and assigned for the administration of the medication for your student.

It is ***illegal*** for any student to carry medication or to dispense medication without the Health Office's knowledge and the accompanying form fully completed.

If you have any questions, please contact the School Nurse.

MANASQUAN SCHOOL DISTRICT

SCHOOL HEALTH SERVICES PROGRAM

Authorization for Medication

If medication is to be taken during school or school sponsored activities, complete this form.

A. This section to be completed by the parent or guardian

Student's Name:_________________________________ Date of Birth:____________

Home Address:_________________________________ Gender:______ Grade ______

Physician: _________________________________

Physician's Address: _____________________________ Telephone #:_____________

______ I request that my child be assisted in taking the medicine(s) described below at school, by legally authorized persons.

______ I request that my child be permitted to self-administer the medicine(s), ***for a life threatening illness****, both which are described below.

*Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenalin injection to treat a potential anaphylactic reaction.

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

Home Telephone #:________________________ Emergency #:__________________

B. This section to be completed by the physician

Name of medicine(s)	
Form (tabs, caps, inj., etc)	
Dose	
If prescribed daily, what time?	
If prescribed "PRN" describe indications.	
How soon can the medication dose be repeated?	
List significant side effects.	
Is this medication for a life threatening illness?	
Is the child authorized to self-administer the medication?	
Has the child been trained by the physician?	
Length of time this treatment is recommended?	
Other information or concerns	

Medical Provider's Signature: ______________________________Date: ____________

Waiver of Liability

The Manasquan Board of Education hereby informs the parents of the above student that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the Manasquan Board of Education harmless against any injury or claims that arise as a result of my child's self administration.

Parent's/Guardian's Signature: ______________________________ Date: ___________

School Physician's Signature: ______________________________ Date: ___________

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FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ____ D.O.B.: ____________

Allergy to: ____

Weight: __________ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

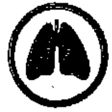
PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

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

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 asthmatic): ______________________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________________ D.O.B.: ____________

Allergy to: ______________________________

Weight: __________ lbs.

Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

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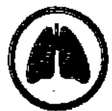

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Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

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

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PARENT/GUARDIAN AUTHORIZATION SIGNATURE ____ DATE ____ PHYSICIAN/HCP AUTHORIZATION SIGNATURE ____ DATE ____

MANASQUAN ELEMENTARY SCHOOL

Health Office
168 Broad Street
Manasquan, NJ 08736
732-528-8810 (Extension 2007)
Fax 732-223-9736

TO: PARENTS/GUARDIANS of ANAPHYLACTIC STUDENTS

FROM: GINA MELILLO RN, SCHOOL NURSE

RE: ANAPHYLACTIC REACTION FORM

TO BE COMPLETED BY PHYSICIAN

STUDENT'S FULL NAME_____________________________
DATE OF BIRTH______________________________

_____The above named student **has not** experienced an anaphylactic reaction
_____The above named student **has** experienced an anaphylactic reaction

Allergen __________________________
Date of Reaction __________________
Symptomatology of Reaction ____
Was an Epi-Pen Used? ______________

Does this student need an Epi-Pen kept at school? Yes _______No_______

For students allergic to tree nuts, peanuts or any other type of nut,
Student needs to sit at nut-free table ____
Student does not need to sit at nut-free table____

Doctor Name_________________________

Doctor Signature ________________________ Date____________

Parent Signature _________________________ Date___________

MANASQUAN ELEMENTARY SCHOOL ____________________

Gina Melillo RN, School Nurse
168 Broad Street, Manasquan, NJ 08736
(732) 528-8810 ext 2007, Fax (732) 223-9736
gmelillo@manasquanboe.org

Dear Parent/Guardian:

Per New Jersey Department of Education, N.J.S.A. 18A:40-12.6, any student who has been diagnosed as being an anaphylactic reactor to one or more allergens shall have the right to receive a prescribed dose of epinephrine by a designated adult trained by the school nurse in the event that the school nurse is unavailable at the time of an episode. The school nurse recently trained willing school employees who were found to be competent, to perform the emergency administration of epinephrine to your child. The delegates have been trained in the use and administration of epinephrine in conjunction with your child's individual Allergy Action Plan.

Please sign below indicating that you are aware of your child's assigned delegates and give permission for these faculty members to **administer emergency epinephrine to your child in the event that a nurse is not available.**

*Please note that Manasquan School District shall have no liability as a result of any injury arising from the administration of epinephrine to the pupil and that the parents or guardians indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to the pupil; and the permission is effective for the school year for which it is granted and is renewed for each subsequent school year. (Per Board of Education Policy #5141.21-R)
It is further understood that delegates from the prior school year will remain in place for those students until such training commences for the new school year.

Student Name____

All Trained Delegates Are Assigned to All Students with a Potentially Life-Threatening Allergic Reaction – see school nurse for list of trained designees 2015-2016 School Year. This form must be completed every school year.

Parent/Guardian Print Name ________________________________Date__________

Parent/Guardian Signature __________________________________Date__________

OR

________We **refuse** the assignment of a delegate at this time

Parent/Guardian Signature__________________________________ Date__________