MANASQUAN SCHOOL DISTRICT

Health Service Team

Elena Blewitt RN, BSN, CSN-NJ – MHS School Nurse
P: (732) 528-8820 x6 F: (732)-528-5114
Eblewitt@manasquan.k12.nj.us

Tricia Cassidy RN, BSN, CSN-NJ – MES School Nurse
P: (732) 528-8810 x 2020 F: (732)-528-5936
Pcassidy@manasquan.k12.nj.us

Valerie Hannafey, RN, BSN – MHS/MES School Nurse
P: (732) 528-8810 x 1402 F: (732)-528-5936
Vhannafey@manaqsuan.k12.nj.us

Food Allergy Questionnaire

To ensure the safety of your child at school and assist the classroom teacher, we would like to ask you to complete in as much detail as possible information regarding your child's food allergies. This information will only be shared with pertinent personnel.

Student's Name _____ Grade _____

Food Allergy/Restriction to:

_____

Avoid the food totally or limit the amount (be specific):

_____

Must avoid the following prepared foods and baked goods:

_____

_____

My child may be in the same room with other children eating these items YES or NO

My child may select items from the cafeteria and knows his/her restrictions YES or NO

These are the symptoms my child has experienced in the past when having an allergic reaction:

_____

Medications necessary to treat my child (Medication requires paperwork must be completed by student's physician & parent)

_____

I would like my child to sit at the **Peanut Free** table in the cafeteria: YES or NO
**Please discuss your decision with your child*

As the parent/guardian it is necessary to provide the school with your child's prescribed medications along with the school forms for medication administration.

I will indemnify and hold the district and its employees harmless should any problems arise.

Parent Name_____

Parent Signature _____ Date _____

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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 allergens:_____

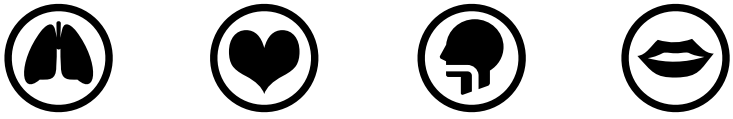
THEREFORE:

☐ 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

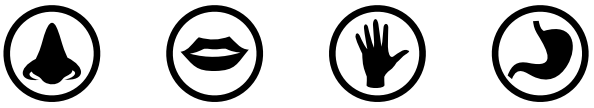
OTHER
Feeling something bad is about to happen, anxiety, confusion

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): _____

_____

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

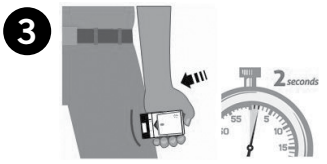
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

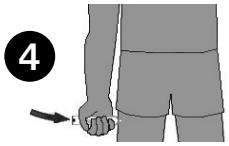
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



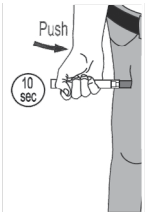
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



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

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

MANASQUAN SCHOOL DISTRICT

Health Service Team

Elena Blewitt RN, BSN, CSN-NJ – MHS School Nurse
P: (732) 528-8820 x6 F: (732)-528-5114
Eblewitt@manasquan.k12.nj.us

Tricia Cassidy RN, BSN, CSN-NJ – MES School Nurse
P: (732) 528-8810 x 2020 F: (732)-528-5936
Pcassidy@manasquan.k12.nj.us

Valerie Hannafey, RN, BSN – MHS/MES School Nurse
P: (732) 528-8810 x 2020 F: (732)-528-5936
Vhannafey@manaqsuan.k12.nj.us

Delegation of Epinephrine

(Permission for trained personnel to administer Epinephrine in the absence of the school nurse)

The School Nurse holds ***primary*** responsibility for the administration of epinephrine. The Department of Education, in consultation with the Department of Health, requires trained designees for students enrolled in a school who may require the emergency administration of epinephrine for anaphylaxis *when the school* ***nurse is not available****.*

In accordance with State Law N.J.S.A. 18A:40-12.6. I grant permission for a trained Epinephrine Delegate to administer epinephrine via a pre-filled auto-injector to my child when the school nurse is not immediately available. This permission will remain in effect for the current school year.

Student Name:_____ Grade: ___

Allergy:_____

I understand that the district and its employees shall incur no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector to the student.

I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to my child.

Parent Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____

PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the School Nurses administering any medication, the health office shall have on file a **Medication Authorization Form** for the involved student, prepared by the student's attending licensed prescriber in compliance with the Manasquan School District's procedures, and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should plan for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of any medication requires both a physician's written order and signed parental permission.

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must in its original container, sealed and unopened with the manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the School Nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified, the student's parent/guardian and physician have signed the Medication Authorization Form, and it has been approved by our School Physician.

6. The parent/guardian must assume responsibility for informing the school, in writing, of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded. Medication authorization is to be renewed, if necessary, every school year.

8. The school district cannot dispense medication without the completed Medication Authorization Form received, reviewed, and approved. It is wise to have it completed and mailed to the Office of the School Nurse in August for the upcoming school year.

Please note: Any missing information on the Medication Authorization Form will render it incomplete and it will be returned to the parent/guardian for correction, which may delay implementation of a pharmacological treatment plan

MANASQUAN SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child 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 MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: Epinephrine _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____

MANASQUAN SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child 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 MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: Benadryl _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____

MANASQUAN SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

*For inhaler, if needed

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child 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 MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____