Montgomery Township School District

Emergency Allergy Action Plan

School Year: ____________________

Affix Student's Picture Here

NO LARGER THAN THIS SQUARE

Student's Name: ____ DOB: ______/______/_____

Teacher: ______________________________ Home Room: _________________ Grade: _________

Physician/Health Care Provider to complete & sign:

List all known life-threatening allergens: ____

Asthma: ☐- **Yes (increased risk of severe reaction)** ☐- **No**

The following statements apply ONLY to food allergens:
Extremely Reactive to the following food(s): ____
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.

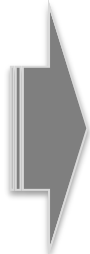
SEVERE SYMPTOMS after suspected or known ingestion or exposure to allergen:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, Blue, Faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble swallowing or breathing
MOUTH:	Obstructive swelling (tongue and /or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itch rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/ bronchodilator† if asthma (only RNs may administer)*

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6.

†Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE!**

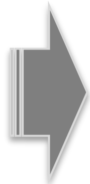
Medications/Dosage:

Epinephrine (auto-injector dose): ____
Administer a second dose of epinephrine if student's condition does not improve within 10-15 minutes after the first dose is given: YES / NO

Other (e.g., inhaler-bronchodilator if asthmatic):______________________________________
(*Delegate cannot administer)

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth/throat
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/stomach ache



1. **GIVE ANTIHISTAMINE***
2. Monitor student's condition
3. If symptoms progress (see above). **USE EPINEPHRINE!**

Antihistamine (dose): ____
(*Delegate cannot administer)

TURN FORM OVER

Capacity for self-administration of epinephrine

Physician/Healthcare Provider should initial applicable statement:

_____ Student **must carry** his/her epinephrine during the school day and is **capable of self-administration**. He/she has received instruction, and demonstrates the proper use of epinephrine using a training device. **If for any reason the student cannot self-administer, the nurse, or delegate (trained by the certified school nurse) will administer the epinephrine.** I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity for self-administration** of epinephrine, but will **carry** this medication to be administered by a nurse or delegate (trained by the certified school nurse) in the event of an emergency. Transportation services will be notified. I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity** for self-administration of epinephrine and **will not carry** this medication.

X____/____________

Physician/Healthcare Provider Signature *Date*

Physician/Healthcare Provider Stamp

Parent or Guardian to complete & sign:

1. Student's epinephrine location (Check all that apply):

☐- Health Office ☐- Carried by Student ☐-Backpack ☐-Classroom (indicate room number):_______

☐-Carried by Delegate ☐-Other Location: ____

2. Student must sit at the peanut-free lunch table **(applicable to grades 1 – 4 only)**: ☐-Yes ☐-No

Emergency Contact Information:

Please PRINT LEGIBLY contact names and phone numbers in order of priority

______________________________/________________/________________/________________

1. Parent/Guardian Name (PRINT) *Preferred Phone* *Phone Alt 1* *Phone Alt 2*

______________________________/________________/________________/________________

2. Parent/Guardian Name (PRINT) *Preferred Phone* *Phone Alt 1* *Phone Alt 2*

______________________________/________________/________________/________________

3. Emergency Contact Name (PRINT) *Preferred Phone* *Phone Alt 1* *Phone Alt 2*

PLEASE NOTE: For students with diagnosed life-threatening allergies, the following bulleted items must be provided & updated each school year for emergencies during school and off-campus events (e.g. field trip, overnight trip, sports.)

- All emergency medications as noted by the student's physician with current expiration date
- If a 2nd dose of epinephrine is authorized by Health Care Provider (see front of form), please provide two auto-injectors.
- A copy of this MTSD Allergy Action Plan for the current school year

Be advised that your child will not be allowed to attend off-campus events without their prescribed emergency meds and completed current MTSD Allergy Action Plan.

I understand that pursuant to N.J.A.C. 18A:40-3.3, a trained delegate may 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.*

*Parent/Guardian Signature: X*______________________________________/ *Date:*__________________

*School Nurse Signature: X*_______________________________________/ *Date:* __________________