New Milford Schools
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 Asthma? ☐ Yes ☐ No
Peanut/Allergen Free Table? ☐ Yes ☐ No Allergy Tested? ☐ Yes ☐ No

This consent order is effective for the _______ school year only and must be renewed annually.

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 ☐
Give Antihistamine & Epinephrine at same time ☐
Give Antihistamine first, observe for further symptoms and give epinephrine PRN ☐

***Please note- in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

☐ This student has been trained and is capable of self-administration of the following medication(s) named above. ☐ Epinephrine – single dose unit ☐ Epinephrine & antihistamine – single dose unit
*Under NJ state law, orders for antihistamine alone cannot be self administered

☐ 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

Two current single dose Epinephrine auto-injectors 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 New Milford School District shall 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 the New Milford School District Policy are followed, I shall indemnify and hold harmless the New Milford School District and it's employees or agents against any claims arising out of administration of medication by my child.

____ ______________

Signature of Parent/Guardian Date

Please sign

I understand that under NJ state law, a trained delegate will 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 Signature Date

Emergency Calls

1. Dr. ________________________________ Phone Number: ____________________
2. Parent ______________________________ Phone Number: ____________________
   Parent ______________________________ Phone Number: ____________________
3. Emergency Contact
   Name/relationship Phone Number
   a. ___________________________________ a. ______________________
   b. ___________________________________ b. ______________________

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Signature of School Nurse Date