

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:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- 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): _____

MONTCLAIR PUBLIC SCHOOLS

PART 2: To be completed by Parent/Guardian

A. Parent/Guardian permission for School Nurse or Staff Delegate administration of Epinephrine Auto-Injector. In the absence of a School Nurse, the antihistamine will be omitted.

To be signed by Parent/Guardian: I give my permission for the school nurse or trained staff delegates to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required. I disclaim all liability of the Montclair Board of Education as it concerns the use of this medication. **I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.**

Parent/Guardian Signature

Date

B. Parent/Guardian Permission for Self-Administration of Epinephrine Auto-Injector with School Nurse or Staff Delegate Supervision

To be signed by Parent/Guardian: I give my permission for my child to self-administer the medication **as described on the reverse side** in the presence of a school nurse or staff delegate. I will notify the school nurse immediately if this medication is no longer directed by the physician. I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the pupil. **I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.**

Parent/Guardian Signature

Date

C. Student Agreement for Self-Administration of Epinephrine Auto-Injector with School Nurse or Staff Delegate Supervision

To be completed by the student: I understand that I will use this medication as directed by my physician under the supervision of a school nurse or staff delegate. I will be responsible and discreet using the medication as described on the reverse side and will have this medication readily accessible. I have been instructed how to self-administer this medication, and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container. **I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication. I disclaim all liability of the Montclair Board of Education as it concerns my use of this medication.**

Parent/Guardian Signature

Date

D. Declination of Staff Delegate Supervision for Middle and High School Students

I choose to decline a staff delegate assigned to my child for all school sponsored activities when a nurse is not present. **I understand that the school district shall incur no liability as a result of this decision.**

Parent/Guardian Signature

Date