ANAPHYLAXIS TREATMENT PLAN

Student's Name: _____ **Grade:** _____

Parent/Guardian: _____

Parent/Guardian Phone # Home_____

Work_____ **Cell**_____

Emergency Contacts:

Name: _____ **Phone #:**_____

Name_____ **Phone #:**_____

Doctor's Name: _____ **Phone#:**_____

DOCTOR'S ORDERS

Diagnosis: _____

First Medication to be administered: _____

Dosage _____ **Route**_____ **Frequency** _____

Other Medication to be administered: _____

Dosage _____ **Route** _____ **Frequency**_____

☐ **The student is capable and has been instructed in the proper method of self administration of the above stated medications in accordance with New Jersey Law.**

☐ **This student is not approved to self medicate.**

Doctor's Signature: _____ **Date**_____

The student is responsible for informing the nurse EACH time the medication is administered.

ANAPHYLAXIS TREATMENT PLAN---PARENT/GUARDIAN SECTION

As the parent/guardian of the above named student:

1. **I hereby give my permission for my child to self -administer his/her medication as prescribed by the signed physician.**

2. **I have previously advised the West Deptford Board of Education that my child has _____. This illness/condition does require that he/she take medication. My son/daughter is capable of administering the above-prescribed medication and has been instructed in the proper method of taking the medication by himself/herself. I hereby authorize the Board of Education to allow my child to self-administer this medication. I have been advised by the representatives of the Board of Education that the Board of Education shall not be responsible for any liability or resulting injury to my son/daughter arising from the self-administration of medication. I hereby agree to indemnify and hold harmless the Board of Education, its agent, servants, and/or employees from any liability relating to or resulting from the self-administration of medication by my child.**

3. **I authorize my child to be administered a pre-filled, single dose auto injector mechanism containing epinephrine (provided by me) prescribed by our physician or nurse practitioner, as described above for anaphylaxis in the event that he/she does not have the capability for self-administration of the medication. Epi-pen delegates are in each school building and have been designated to administer a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis to my child. The designee(s) have been properly trained by the school nurse using the "Protocol and Implementation Plan for the Emergency Administration of epinephrine by a Delegate Trained by the School Nurse" established by the Department of Education in consultation with the Department of Health and Senior Services.**

4. **I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that the West Deptford Board of Education and any district employee shall have no liability as a result of any injury arising from the procedures utilized for emergency administration of epinephrine to my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.**

Parent/Guardian's Signature: _____ Date: _____