Dr. Gerald H. Woehr Elementary School 44 North Main St., New Egypt, NJ 08533
Phone 609-758-6800 Fax 609-758-6868

Emergency and Individual Health Care Plan

Student's Potential for Allergen Reaction or Anaphylaxis

Name _____ DOB _____Grade _____
Home Address _____
Parent/Guardian # 1 _____ Relationship _____
Phone numbers - Work _____ Home _____
Parent/Guardian # 2 _____ Relationship _____
Phone numbers - Work _____ Home _____
Other Emergency Contact _____Phone _____
Medical Care Provider _____ Phone _____

By signing this consent you will acknowledge and agree that the Plumsted Township School District and its employees or agents shall incur no liability as a result of any injury arising from following these specified procedures. Furthermore, the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of these specified procedures. In addition, this information may be shared with some staff members as needed for the safety of your child.

_____ _____
Parent/Guardian's Signature **Date**

Allergy Diagnosis description of allergy (exact type of allergen), when first identified, type of reaction and duration, any allergy testing or shots for desensitization, any restrictions, additional medical conditions (asthma etc.):

_____
_____

****Medication(s) if allergen contact or ingestion is suspected give:**

#1_____
Medication/dosage/route

#2_____
Medication/dosage/route

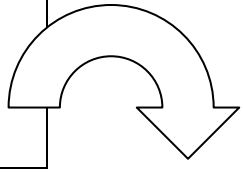
____for ANAPHYLAXIS ONLY (Medical Care Provider check if applicable) in conjunction with self –administration of the auto injection of Epi-Pen (epinephrine) this child may self medicate with a premeasured antihistamine of Benadryl (Diphenhydramine Hydrochloride)

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

1. **Phone 911 inform dispatcher that student is experiencing anaphylaxis.**
2. **Phone Parent/Guardian #1 if unavailable #2, if unavailable Emergency Contact**
3. **Phone Medical Provider**

_____ _____
Medical Provider's Signature **Date**

Medical Provider's Stamp



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In the event the School Nurse is not available and according to the N.J.S.A. 18A:40-12-5 and 12-6 a trained staff member may administer the Epi-Pen only.
The School Nurse will complete the following. The Trained Staff Member will be CPR Certified and be thoroughly trained in the use of the Epi-Pen for this specific student.
Trained Staff Member
Name _____ Location _____

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
MOUTH	itching and swelling of the lips, tongue or mouth
THROAT	itching and/or sense of tightness in the throat, hoarseness and hacking cough
SKIN	hives, itchy rash, and/or swelling abut the face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	"thready" pulse, "passing-out"

PEANUT FREE LUNCH TABLE

My child _____

___Does need to sit at the Peanut Free table.

___Does *not* need to sit at the Peanut Free table.

___Is allowed to eat the school lunches when I have determined by reviewing the monthly menu that it is in no way harmful for him/her.

___Is *not* allowed to eat school lunches.

_____ _____
Parent Signature Date

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Emergency and Individual Health Care Plan

Date _____

Dear Parents/Guardians,

You have indicated that your child**_____**
has a potentially life threatening allergy to _____.

Signs of an allergic reaction include:

Skin - hives, rash, swelling face/extremities
Mouth/Throat - itching swelling lips/tongue swelling, metallic taste, throat tightness
Gastro - nausea, abdominal pain, cramps, vomiting, diarrhea, difficulty swallowing
Respiratory - difficulty breathing, hoarseness, coughing, wheezing
Cardiac - rapid or weak pulse, low blood pressure, unresponsiveness

The severity of symptoms quickly changes and can potentially progress to a life-threatening situation.

In order to be prepared to respond to an anaphylactic emergency the school requires the following:

1. Have the **Emergency and Individual Health Care Plan** completed by your medical provider and return it to the nurse**.** This form contains instructions the school nurse is to follow in the event your child experiences an allergic reaction or anaphylaxis at school.

2. Provide the correct medication(s) in the original container as prescribed by the medical provider and make sure the **medication(s) do/does not expire during the course of the school year. (children are not permitted to bring medications to the nurse)**

Any questions regarding this protocol please feel free to contact the nursing office at 609-758-6800 ext. 123.

Sincerely,

Denise Liotti
School Nurse

Revised 10/20/14