



# *The Academy of the Most Blessed Sacrament*

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August 2025

Dear Parents,

Enclosed please find an **Allergy Action Plan and Asthma Treatment Plan** for your child, if needed. Please have your child's health care provider complete and sign the front page of the form. A parent must complete the emergency contacts on the second page and also sign the form at the bottom of the front page.

The other form that is enclosed is the **Consent for Administration of Epinephrine by a Delegate**. This form needs to be signed by a parent.

Due to the changes in the N.J. law concerning allergies and epinephrine, designees will be trained in the administration of epinephrine via pre-filled auto-injector (Epi-Pen, Auvi-Q, Adrenaclick.) The designees will administer epinephrine only in the absence of the nurse. The designees **MAY NOT** administer Benadryl or any other antihistamine prior to giving epinephrine. Only a nurse may administer Benadryl and a second dose of epinephrine (if needed).

**Please complete and return these forms along with a pre-filled auto-injector (Epi-Pen, Auvi-Q, Adrenaclick) and Benadryl (if indicated by the doctor) on the first day of school, Wednesday, September 3, 2025.**

Thank you for your help in this matter!

Sincerely,  
School Health Office



*The Academy of the Most Blessed Sacrament, motivated by the love of Christ, ensures that each student receive a superior education in a caring Catholic environment. Committed to the pursuit of excellence, students are guided through a personal journey of faith, education and service in order to reach their God given potential to become individuals capable of living in a changing and complex society.*

**FARE**

Food Allergy Research &amp; Education

**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

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 allergens:** \_\_\_\_\_**THEREFORE:** If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms. If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.**FOR ANY OF THE FOLLOWING:  
SEVERE SYMPTOMS****LUNG**

Shortness of breath, wheezing, repetitive cough

**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness

**THROAT**

Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**

Significant swelling of the tongue 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 emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS****NOSE**

Itchy or runny nose, sneezing

**MOUTH**

Itchy mouth

**SKIN**

A few hives, mild itch

**GUT**

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.****FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

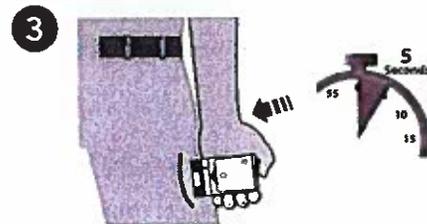
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



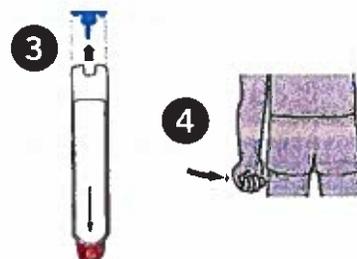
### HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



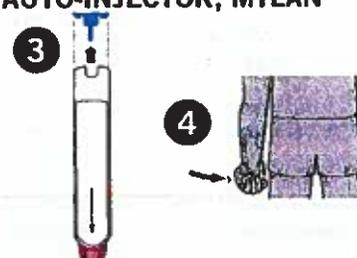
### HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



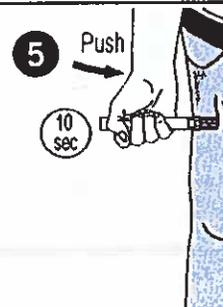
### HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



### HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

### OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

#### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_



# Asthma Treatment Plan – Student Parent Instructions



The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
  - Child's name
  - Child's date of birth
  - Child's doctor's name & phone number
  - An Emergency Contact person's name & phone number
  - Parent/Guardian's name & phone number
- Your Health Care Provider will complete the following areas:**
  - The effective date of this plan
  - The medicine information for the Healthy, Caution and Emergency sections
  - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
  - Your Health Care Provider may check "OTHER" and:
    - ◆ Write in asthma medications not listed on the form
    - ◆ Write in additional medications that will control your asthma
    - ◆ Write in generic medications in place of the name brand on the form
  - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:**
  - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
  - Child's asthma triggers on the right side of the form
  - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- Parents/Guardians:** After completing the form with your Health Care Provider:
  - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
  - Keep a copy easily available at home to help manage your child's asthma
  - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

## PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.**

**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY**

- I do request that my child be **ALLOWED** to carry the following medication \_\_\_\_\_ for self-administration in school pursuant to N.J.A.C.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.
- I **DO NOT** request that my child self-administer his/her asthma medication.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

CONSENT FOR ADMINISTRATION OF EPINEPHRINE VIA AUTO-INJECTOR  
BY A DELEGATE

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

If the procedures specified in N.J.S.S. 18a:40-12.5 AND 12.6 are followed, and the procedures in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, AMBS shall have no liability as a result of any injury arising from the administration of an epinephrine auto-injector to the student.  
(school name)

The parent/guardian shall indemnify and hold harmless the district or school and its employees against any claims arising out of the administration of the administration of the epinephrine auto-injector or the student.

It is the parent/guardian's responsibility to provide a current epinephrine auto-injector. Permission and physician's order are effective only for the school year for which they are granted and must be renewed each subsequent school year.

Reviewed with parent/guardian by \_\_\_\_\_ Date \_\_\_\_\_

Signature

Parent/Guardian Statement:

1. In the event of a potentially life-threatening allergic reaction, as described in the attached physician's order, I authorize the emergency administration of epinephrine via auto-injector to my child \_\_\_\_\_ by the school nurse or by the delegate \_\_\_\_\_, who is properly trained according to the Protocol and Implementation Plan.
2. I understand that the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration by a Delegate Trained by the School Nurse" are followed by AMBS, as well as its employees or agents, shall have not liability as a result of any injury arising from the administration of the epinephrine auto-injector to my child.  
(School Name)
3. I indemnify and hold harmless \_\_\_\_\_ as well as its employees and agents, against any claims arising out of the administration of an epinephrine auto-injector to my child.  
(School Nurse)
4. I will provide a current epinephrine auto-injector to the school, and will replace it with a new one at least 2 weeks before it expires.
5. I understand my permission is granted only for this school year.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Relation to student \_\_\_\_\_

