Re: ______________________________

Dear Parent/ Guardian,

Our records indicate that your child has a serious, life-threatening food allergy and has Epinephrine via a pre-filled auto-injector mechanism (commonly known as EpiPen or Twinject) prescribed by his or her personal physician.

P.L. 2007, Chapter 57 stipulates

> "The school nurse shall have the primary responsibility for the administration of epinephrine. The school nurse shall designate, in consultation with the board of education, or chief school administrator of a nonpublic school, additional employees of the school district or nonpublic school who volunteer to administer epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis when the nurse is not physically present at the scene. "

Attached is a copy of the *Delegate Consent Form* for you to review, and sign if appropriate for your child.

Should you have any questions or concerns, please feel free to call upon your school nurse.

Very truly yours,

Lorraine Hanon, RN
[illegible], RN/[illegible]

School Nurse

Release of Information Form

It is necessary to obtain written parental permission for release of medical records/information. Completion of this form with parental signature will constitute authorization for release of medical records/information.

I hereby request and authorize ______________________________ to release the
Name of Physician/Provider

records/information of my son/daughter, ______________________________ to be sent to:
Sudent Name

All Saints Catholic Academy
Name of School

19 W 13 st
Address

Bayonne, NJ 07002
City/Town State Zip Code

____
Parent/Guardian Name (Print)

______________________________ ______________
Parent /Guardian Signature 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, _________________ shall have no liability as a result of any injury arising from the
(school name)
administration of an epinephrine auto-injector to the student.

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 any teacher__________, 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 ________, as well as
(School Name)
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.
3. I indemnify and hold harmless____________ as well as its employees and agents, against any
(School Nurse)
claims arising out of the administration of an epinephrine auto-injector to my child.
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 2011-2012 school year.

Parent/Guardian signature ____ Date _____________

Relation to student ___________________________

CLHF #19 Rev. 8/11

Catapult Learning™

Medical Authorization for Severe Allergic Reaction

For School Year _______

Student's Name ______________________________ DOB __________ Date ____________

TO BE COMPLETED BY PHYSICIAN:

If stung by ____

After ingesting ____

After exposure to ____

1. Immediately give ____________________ whether or not symptoms are present.
   (medication/dose/route)
2. (OR) Observe student for up to 30 minutes and only give ______________________
   (medication/dose/route)

if the following symptoms occur:

___	MOUTH:	itching and/or swelling of lips, tongue, or mouth.
___	THROAT:	itching and/or sense of tightness in throat, hoarseness, hacking cough, and/or difficulty hacking cough, and/or difficulty swallowing.
___	SKIN:	itching, hives, rash, and/or swelling in any area of body.
___	ABD:	nausea, abdominal cramps, vomiting, and/or diarrhea.
___	LUNG:	shortness of breath, sense of tightness in chest, repetitive coughing, and/or wheezing
___	HEART:	rapid weak pulse, dizziness and/or fainting.
___	OTHER:	______________________________

STUDENT HAS HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS: Yes No

IF EPINEPHRINE AUTO-INJECTOR IS PRESCRIBED, CHECK ONE:

____ Student is **not** capable of self-administration.

____ Student **is** capable of self-administration and has been instructed in its use and may carry epinephrine auto-injector with him/her.

If epinephrine is given, EMS will be immediately contacted.

Physician's Signature: ______________________________ Date: ____________

Please print or stamp Name: ________________________

Address: ________________________

Phone: ________________________

TO BE COMPLETE BY PARENT/GUARDIAN:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve ________________ and its employees of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the physician.

Parent/Guardian Signature ______________________________ Date ______________

Home Phone ________________________ Emergency Phone ____________________

STUDENTS WITH SPECIAL HEALTH CARE NEEDS

EMERGENCY PLAN

Student: ______________________ Date: ______________

Birthdate: ____________ *see reverse side for parent/guardian information

Preferred Hospital in case of emergency: ______________________

Healthcare Provider: ______________________ **Phone:** ______________

STUDENT - SPECIFIC EMERGENCIES

If You See This	*Do This*

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
   a. State who you are.
   b. State where you are.
   c. State problem.
4. The following staff members are trained to deal with an emergency, and to initiate the appropriate procedures:
   a. School nurse and designee.

Adapted From: *Guidelines for Serving Students with Special Healthcare Needs,* Utah State Office of Education, August 1992