FORT LEE SCHOOL #3
HEALTH OFFICE
2405 Second Street
Fort Lee, NJ 07024
Tel: 201-585-4640 x3502 Fax: 201-585-1488
Email: ablee@flboe.com

Important Notice

School nurse will NOT administer any medication to students unless they have received a medication form properly completed and signed by the doctor and parent; and the medication has been received in an appropriately labeled container. In fairness to those giving the medication and to protect the safety of your child, there will be no exception to this policy.

The highlighted items below are necessary in order for your child to receive their REQUIRED allergy medication for this school year.

- **Request for Giving Medication At School Form** completely filled out and signed by you AND your child's physician (Form 02-D-18)
- **Antihistamine Administration of Medication Form** completely filled out and signed by you AND your child's physician (Form 02-D-34-C)
- **Epinephrine Administration of Medication Form** completely filled out and signed by you AND your child's physician (Form 02-D-34-D)
- **Food Allergy and Anaphylaxis Emergency Care Plan** completely filled out and signed by you AND your child's physician.
- One box two (2) unexpired Epinephrine Auto Injectors (ex. Epi-Pen, Auvi-Q) in the original box with pharmacy label.
- Unexpired antihistamine (ex. Benadryl, Zyrtec, Claritin) in the original box.

If you have any questions about this policy or other issues related to the administration of medication in the schools, please feel free to contact me.

Thank you for your cooperation.

Regards,
Aben Lee, RN, MSN
School #3 Nurse

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

REQUEST FOR GIVING MEDICATION AT SCHOOL
FORM 02-D-18

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: _____ Date of Birth: _____

Allergies: _____ Grade: _____ Current Weight: _____

Diagnosis/Medical Condition: _____

Name of Medication: _____ Dose to be administered: _____

Route: _____ Time to be administered: _____ am/pm (please circle)

Possible side effects of medication: _____

Intervention to be rendered for an adverse reaction: _____

_____

Dates to be dispensed (Please check): ☐ School year _____ to _____ ☐ Half days ☐ Field

Trips (including overnight trips) ☐ Other prescribed time period: _____

* _____ _____
PHYSICIAN SIGNATURE **DATE**

* _____
PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: _____
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: _____

_____ _____ _____
Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by _____ **School Nurse-teacher**
Name **School Doctor**

On _____.
Date

REV. 09/2023

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

ANTIHISTAMINE ADMINISTRATION OF MEDICATION FORM (FOR LIFE THREATENING ALLERGIC REACTION IN ADDITION TO THE FARE EMERGENCY CARE PLAN)
FORM 02-D-34-C

This form is required for all over-the-counter and/or prescription medication(s) to be administered during school hours. The medication(s) will be supplied by the parents and brought to the school nurse in the original container appropriately labeled by the pharmacy and physician. **All medication must be picked up at the end of the school year.**

Student's Name: _____ Date of Birth: _____

Allergies: _____ Grade: _____ Current Weight: _____

Diagnosis/Medical Condition: _____

Name of Antihistamine: _____ Dose to be administered: _____

Route: _____ Time to be administered: _____ am/pm (please circle)

Possible side effects of medication: _____

Intervention to be rendered for an adverse reaction: _____

_____

* _____ _____
PHYSICIAN SIGNATURE DATE

* _____
PHYSICIAN PRINTED NAME

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)

This section is to be completed by the Parent/ Legal Guardian

Please initial the following:

- I hereby give the school nurse/school physician permission to administer the above stated medication. Initial: _____
- I also, give the school nurse/school physician permission to contact my child's physician regarding the ordered medication, as needed. Initial: _____
- I am aware that this medication can only be administered by a school nurse during school hours. Initial: _____

_____ _____ _____
Parent/ Guardian Signature Emergency contact number Date

Received by school and reviewed by _____ School Nurse-teacher
Name School Doctor

On _____.
Date

REV. 02/09/2022

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

SCHOOL YEAR ~~2022-2023~~ 2023-2024
EPINEPHRINE ADMINISTRATION OF MEDICATION FORM
FORM 02-D-34-D

To be completed by the examining physician and parent and returned to the School Nurse/Teacher.

Permission is effective only for the school year for which it is granted and must be renewed annually. Medication must be in ORIGINAL container, appropriately labeled by the pharmacy or physician.

Student's Name _____ _____ DOB _____ Grade _____
(Last) (First)

A. TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS _____

NAME OF THE MEDICATION: EPINEPHRINE AUTO INJECTOR

BRAND NAME _____ MANUFACTURER _____ EXPIRATION DATE

DOSAGE _____

FREQUENCY _____

FOLLOW - UP INSTRUCTIONS _____

_____ _____
Physician Signature **Date**

_____ _____
Physician Printed Name **PHYSICIAN STAMP**
(TO INCLUDE ADDRESS & PHONE NUMBER)

B. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I understand that the district and its employees or agents shall incur no liability as a result of injury arising from the administration of medication. I indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of medication.

_____ _____
Parent/Guardian Signature **Date**

_____
Parent/Guardian Printed Name

C. TO BE COMPLETED BY HEALTH SERVICES STAFF:

Form reviewed _____ (Date) _____

_____ _____
School Physician's Signature School Nurse/teacher's Signature

REV. 02/09/2022

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

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: ☐ 0.1 mg IM ☐ 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

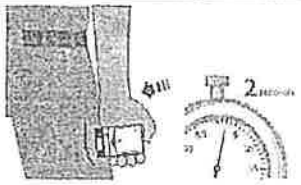
PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

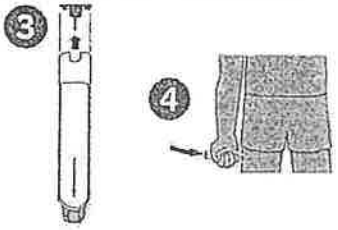
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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 until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



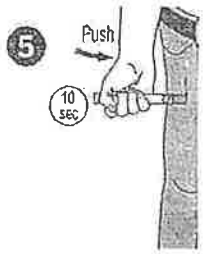
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.



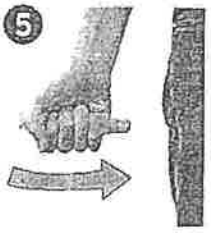
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

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.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. 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: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019