

**HADDONFIELD PUBLIC SCHOOLS**  
**AUTHORIZATION FOR ADMINISTRATION OF ANTIHISTAMINE and/or EPINEPHRINE**

The New Jersey State Law and the Haddonfield Board of Education require a healthcare provider's written order and parent/guardian authorization for a nurse to administer epinephrine. This medication must be in a pharmacy prepared container and labeled with the name of the student, the healthcare provider's name and date:

**HEALTHCARE PROVIDER'S ORDER**

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_

The above named student is under my care for: \_\_\_\_\_

History of anaphylaxis is: Actual \_\_\_\_\_ Potential \_\_\_\_\_

Description of anaphylaxis event: \_\_\_\_\_

Signs of Allergic Reaction:

Mouth (Itching, swelling of oral area)	<u>X</u>	Throat (Tightness, cough, hoarseness)	<u>X</u>
Skin (Hives, rash, swelling of face/extremities)	<u>X</u>	GI (Nausea, vomiting, abdominal cramps/diarrhea)	<u>X</u>
Lungs (Shortness of breath, cough/wheeze)	<u>X</u>	Heart (Rapid, thready pulse)	<u>X</u>

Medication: Antihistamine: \_\_\_\_\_ Dosage: \_\_\_\_\_

To be given for: \_\_\_\_\_

Medication: Epi-Pen Dosage: \_\_\_\_\_

To be given for: Signs and symptoms of anaphylaxis

This student has been trained and is able to self-administer the prefilled auto injector mechanism of epinephrine.  
Yes \_\_\_\_\_ No \_\_\_\_\_

If the student is unable to self-administer the epinephrine, the certified school nurse will administer the epinephrine. If, for any reason, the certified school nurse is unable to administer the epinephrine, a predetermined delegate trained by the school nurse will administer the epinephrine. If, for any reason, the predetermined delegate is unable to administer the epinephrine, 9-1-1 will be called to support the student. **Antihistamines cannot be given by the delegate. If the school nurse is not available, the delegate will administer epinephrine only and call 9-1-1.**

I understand that after the administration of epinephrine in the school setting, 9-1-1 will be called to transport the student to the nearest hospital for further evaluation and treatment.

Print Healthcare Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

HEALTHCARE PROVIDER'S SIGNATURE (no stamps)

DATE

This authorization is effective only for the school year in which it is granted. N.J.S.A. 18A:40-12.5

**HADDONFIELD PUBLIC SCHOOLS  
AUTHORIZATION BY PARENT/GUARDIAN FOR THE  
ADMINISTRATION OF EPINEPHRINE**

I hereby request that the pre-filled, single dose auto-injector mechanism containing epinephrine ordered for my child \_\_\_\_\_ by \_\_\_\_\_ and provided to the school by myself, \_\_\_\_\_  
(Healthcare Provider's name) Please Print  
be administered by the certified school nurse or the predetermined delegate assigned to my child.

I understand that the school nurse shall delegate, in consultation with the Principal and the Board of Education, another employee/s of the school district to administer a pre-filled, auto-injector mechanism containing epinephrine. (New Jersey State Board of Nursing NJSA 18A:40-12.5 and 12.6 [P.L. 199.C3687]). I understand that, if for any reason, the certified school nurse cannot administer the epinephrine, the predetermined delegate will administer the epinephrine. I understand that, if for any reason the predetermined delegate cannot administer the epinephrine 9-1-1 will be called to support my child.

I give my permission for the certified school nurse to contact the above healthcare provider with regard to my child.

I understand and agree that if the procedures specified in the NJSA 18A:40-12.5 are followed that the district of Haddonfield, the Haddonfield Board of Education or its employees or agents shall have no liability as a result of any injury arising from the administration of a pre-filled auto-injector mechanism containing epinephrine to my child.

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, auto-injector mechanism containing epinephrine to my child.

I understand that after the administration of epinephrine in the school setting, 9-1-1 will be called to transport the student to the nearest hospital for further evaluation and treatment.

PRINT PARENT/GAURDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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

DATE: \_\_\_\_\_

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO CHILD

\*This Authorization is effective only for the school year in which it is granted. N.J.S.A. 18A:40-12.5