

BORDENTOWN REGIONAL SCHOOL DISTRICT

School Health Services

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**Epinephrine Auto Injection Administration Order - To be completed by physician
(Epi-pen, Auvi-Q, or other epinephrine)**

Student's Name: _____ Date: Begin: _____ End: _____

Allergy (s): _____

Reaction to allergen occurs if: _____ Contact _____ Inhalation _____ Ingestion _____

- _____ I certify that this student has experienced Anaphylaxis
- _____ No known history of Anaphylactic reaction
- _____ Student has known history of asthma

Epinephrine Medication _____ **For over 66 lbs (0.3mg)** _____ **For under 66 lbs(0.15mg)**
Antihistamine:(Medication/dosage/route): _____

Symptoms:	Give checked medication as determined by Physician:	
If an exposure to the allergen has occurred, but there are NO symptoms:	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Skin: Hives, itchy rash, swelling of face or extremities	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Throat: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Lung: Shortness of breath, repetitive cough, wheezing	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Heart: Weak/thready pulse, low blood pressure. fainting, pallor, cyanosis.	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
If reaction is progressing, several of the above areas affected:	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Other Symptoms/Additional instructions:	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine

Epinephrine Auto Injection Form continued on other side --- OVER----->

Self Administration (requires Physician's, School Nurse's, and Parent's Signature below):

_____ I verify that the student has been adequately trained and is capable of self-administering the medication listed below in a life threatening situation.
_____ Student **NOT** capable of self administering.

Physician's Signature _____ **Date:** _____

Office Stamp:

Parent signature: _____ **School Nurse's Signature:** _____

Delegation-----To be completed by Parent/Guardian (Please initial):

****According to NJ state law, if the nurse is not physically present→trained designee will give Epinephrine only. Any antihistamine order will be disregarded.****

_____ **If the nurse is unavailable, a delegate IS permitted to administer Epinephrine.**

_____ **If the nurse is unavailable, a delegate is NOT permitted to administer Epinephrine.**

I acknowledge that the Bordentown Regional School District and its employees or agents shall incur no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to my child. I indemnify and hold harmless the Bordentown Regional School District and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to my child.

Parent/guardian signature _____ **Date** _____

Parent/Emergency Contacts:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____