Somerset Hills School District
Authorization for Emergency Medications

Student Name: _____
Date of Birth: _____School Year: _____
Allergic To: _____

Signs of Allergic Reaction: Circle all that apply

Systems:	**Symptoms:**
Mouth	Itching and swelling of the lips, tongue or mouth
Skin	Hives, itchy rash, and/or swelling about face or extremities
Throat	Itching and/or tightness in the throat, hoarseness and cough
Abdomen	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lungs	Shortness of breath, repetitive cough, wheezing or chest tightness
Heart	Thready pulse, fainting

All above symptoms can potentially progress to a life-threatening situation.

I hereby certify that the student listed above has been instructed in and is fully capable of the self-administration of the EpiPen**.** This student may carry his or her EpiPen.
Yes _____ No _____

Action Plan for an Allergic Reaction:

Chose from the following options:

1. **Benadryl**
   NO_____
   YES _____ Benadryl_____mg. p.o.

Notify parent. Students with allergic reaction will be sent home.

In the absence of the school nurse, the order for Benadryl should be disregarded and epinephrine is to be immediately administered by the designated delegate.

2. **Epinephrine auto-injector 0.15mg _____**
   Epinephrine auto-injector 0.3mg _____

If symptoms of anaphylaxis persist repeat EpiPen administration in 10-15 minutes.
YES_____ NO_____

Call Rescue Squad or 911 and ask for advance life support. Notify parent/guardian. Transport to nearest Emergency Room. Student must have access to epinephrine for school related activity and/or field trip.

Physician Signature:_____Date_____
Physician Stamp:

Parent Signature: _____ Date _____