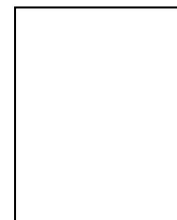
Berkeley Heights Public Schools
Berkeley Heights, NJ

Medication Authorization Form/Allergy Action Plan
School Nurse Order



Student's Name_____________________**D.O.B**____________ **Teacher**______________

ALLERGY TO:__________________________________

Asthmatic Yes ☐ No ☐

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*		Epinephrine	Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• Throat+	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
• Lung+	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
• Heart+	Thready pulse, low B/P, fainting, pale, cyanosis	Epinephrine	Antihistamine
• Other+	________________________________	Epinephrine	Antihistamine
• If reaction is progressing (several of the above areas affected)		Epinephrine	Antihistamine

+The severity of symptoms can quickly change. + **Potentially life-threatening**

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg. Twinject 0.15mg

Antihistamine: give____
Medication/dose/route

Other: give____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr.____________________________ Phone number___________________________
3. Parent (home) ___________________ (cell) __________________________________
4. Emergency Contacts:

Name and relationship Phone numbers

a.______________________ (1)___________________ (2)______________________

b.______________________ (1)___________________ (2)_________________

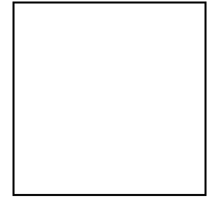
**** EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, IMMEDIATELY TRANSPORT TO MEDICAL FACILITY!*****

Parent/Guardians Signature ____ Date __________________

Doctor/Nurse Practitioner Signature ______________________________________ Date__________________

Physician Stamp ____

School Nurse Reviewed ____ Date__________________



Berkeley Heights Public Schools

Berkeley Heights, NJ

Medication Authorization Form Allergy/Action Plan
Designee order

Student's Name______________________**D.O.B**____________ **Teacher**______________

ALLERGY TO:____ Child's photo

Asthmatic Yes ☐ No ☐

STEP 1:

In the event of contact to/ingestion of an allergen or insect sting/bite *immediately* administer:

Epinephrine: inject (circle one)	EpiPen (0.3 mg.)	EpiPen Jr.(0.15 mg)

STEP 2:

Emergency calls

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr.______________________________ Phone number______________________________
3. Parent (home)____________________ (cell)_______________________________________
4. Emergency Contacts:
   Name and relationship Phone numbers

____________________________ (1) __________________ (2) _______________________

____________________________ (1) __________________ (2) _______________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, IMMEDIATELY CALL 911 AND TRANSPORT TO MEDICAL FACILITY!

Parent/Guardians Signature ____ Date ___________________

Doctor/Nurse Practitioner Signature __________________________________ Date___________________

Physician Stamp ____

School Nurse Reviewed ____

Berkeley Heights Public Schools
Berkeley Heights, NJ

Student Allergy Information Sheet

Student's Name_____________________D.O.B_________ Teacher______________
Please complete this form and return to school health office so that your child's health and allergy information is current.

Indicate allergies:
___ Insect stings (type): ____

___Food (type): ____

___Animals (type):____

____Drugs (list): ____

___Other (list): ____

List symptoms:
___ difficulty breathing _____ coughing _____wheezing _____

___difficulty swallowing _____ vomiting

___loss of consciousness

___swelling Severity_____________ location ______________________ hives _____

Other symptoms ____
Date of most recent allergic reaction. _____________
Has hospitalization or emergency room care been needed in the past year for allergies?
___No ___Yes

Date/details/medication required:
____

____
Are there any other changes in your child's health since last September?
____

____
*****Please contact the school nurse with information related to changes in your child's condition changes during the school year. *****

Parent/Guardians Signature _________________________________Date _________________