REQUEST FOR INJECTION BY EPINEPHRINE PEN

Student Name ____ Grade ______________

School Year __________________________________

My child is severely allergic to the following substances:

____

____

My child needs to receive immediate medication with an epinephrine pen ("epi-pen") if he/she is exposed to any of the above substances or has any of the common signs or symptoms of anaphylaxis which includes hives or rash, swelling of face and/or extremities, tingling of lips and mouth, flushing of face or body, coughing, wheezing, dyspnea (shortness of breath), nausea, vomiting, abdominal cramps, diarrhea, tachycardia (increased heart rate), postural hypotension (low blood pressure), and syncope (fainting). This also applies to other signs on individualized care plans.

My child will (check one):

__________Be able to self-administer the epi-pen injection

__________Not be able to self-administer the epi-pen injection

SELF ADMINISTRATION

Enclosed is written certification from my child's physician that my child has asthma or another potentially life-threatening illness or is subject to a life-threatening allergic reaction and is capable of, and has been instructed in, the proper method of self-administration of medication.

I verify that my child has a potentially life-threatening illness or is subject to a life-threatening allergic reaction and **has been instructed in self-administration** of the prescribed medication in a life-threatening situation. **I hereby give permission for my child to self-administer prescribed medication.** This permission is effective only for this school year and I can renew my consent in future years. I further acknowledge that if procedures specified by New Jersey law are followed, the Link Community Charter School, its Board of Trustees, employees, and/or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the Link Community Charter School, its Board of Trustees, employees, and/or agents against any claim arising out of self-administration of medication by my child.

Parent/Guardian Signature ____ Date _______________

Parent/Guardian Signature ____ Date _______________

Principal's Signature ____ Date _______________

School Nurse's Signature ____ Date _______________

UNABLE TO SELF-ADMINISTER

Enclosed is my child's physician's written order to Link Community Charter School indicating that my child cannot self-administer and needs administration by the school nurse or designee (if applicable).

Treatment by a designee when a nurse is not present: N.J.S.A. 18A:40-12.6 directs that a school nurse shall designate additional employees of Link Community Charter School who volunteer to administer epi-pen injection to a student who has anaphylaxis when the school nurse is not physical present at the scene. The school nurse shall determine that the designees are property trained in the administration of the epinephrine via a pre-filled auto-injector mechanism. Please note that trained nonmedical designees are NOT permitted by law to administer any medications, including antihistamines, other than epinephrine via auto-injector mechanism.

I verify that my child has a potentially life threatening illness or is subject to a life-threatening allergic reaction and is **unable to self-administer** the prescribed medication in a life threatening situation. I hereby request the school nurse or designee (if applicable) to administer the prescribed medication to my child. I understand that under New Jersey law, a trained designee will be assigned to administer epi-pen injection to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained designee. This permission is effective only for this school year and I can renew my consent in future years. I further acknowledge that if procedures specified by New Jersey law are followed, the Link Community Charter School, its Board of Trustees, employees, and/or agents shall incur no liability as a result of any injury arising from administration of the medication to my child. I shall indemnify and hold harmless the Link Community Charter School, its Board of Trustees, employees, and/or agents against any claim arising out of administration of medication to my child.

Parent/Guardian Signature ____ Date _______________

Parent/Guardian Signature ____ Date _______________

Principal's Signature ____ Date _______________

School Nurse's Signature ____ Date _______________

Designee's Signature ____ Date _______________