Saddle Brook Public Schools
MEDICATION AUTHORIZATION FOR SEVERE ALLERGIC REACTION
For School Year _____

Student Name_____ DOB_____ Date_____

TO BE COMPLETED BY PHYSICIAN:

- If stung by_____
- After ingesting_____
- After exposure to_____
- Immediately give_____**whether or not symptoms are present**. Medication/dose/route
- Give _____ if the following symptoms occur:
  Medication/dose/route

_____MOUTH: itching and/or swelling of lips, tongue, or mouth
_____THROAT: itching and/or sense of tightness in throat, hoarseness, hacking cough, and/or difficulty swallowing
_____SKIN: itching, hives, rash, and/or swelling in any area of body
_____GUT: nausea, abdominal cramps, vomiting, and/or diarrhea
_____LUNG: shortness of breath, sense of tightness in chest, repetitive coughing, and/or wheezing
_____HEART: rapid or weak pulse, dizziness and/or fainting
_____OTHER:_____
_____

STUDENT HAS HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS: YES_____ NO_____

*****IF EPINEPHRINE AUTO-INJECTOR IS PRESCRIBED, CHECK ONE:**

_____Student is **NOT** capable of self-administration

_____Student **IS** capable of self-administration, has been instructed in medication use, and may carry epinephrine auto-injector and/or one dose of anhihistamine with him/her.

*****IF ANTIHISTAMINE IS PRESCRIBED TO BE GIVEN BY NURSE PRIOR TO EPINEPHRINE, PLEASE CHECK BELOW:**

_____If a nurse and /or parent is **not** available during school or at any school sponsored event, and the student is having a **severe** allergic reaction, the antihistamine may be **withheld** and Epinephrine may be given by a **trained delegate.** (According to NJ State law, delegates may only administer epinephrine, not oral medications)

If epinephrine is given, EMS will be immediately contacted.

Physician's Signature_____Date_____
Please print or stamp: Name_____
Address_____
Phone_____

TO BE COMPLETED BY PARENT/GUARDIAN:
I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector and/or one dose of antihistamine and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child, or from self-administration when certified by the physician.

Parent/Guardian_____Date_____

Home Phone_____Emergency Phone_____