

PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's Name _____ Birth Date _____ Grade/Teacher _____

The above student is allergic to: _____

- Ingestion Contact Inhalation

Previous episode of anaphylaxis Yes No
 Asthmatic Yes No

MEDICATIONS

ANTIHISTAMINE: Medication _____ Dose _____

Give antihistamine for the following checked symptoms:

- Contact with allergen, with or without symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Other _____

EPINEPHRINE: Medication _____ Dose _____

Give epinephrine for the following checked symptoms:

- Contact with allergen, with or without symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Gut – abdominal cramps, nausea, vomiting, diarrhea
- Lungs – repetitive cough, wheezing, shortness of breath
- Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- Other _____

AFTER GIVING EPINEPHRINE, 911 AND THE PARENT/GUARDIAN WILL BE CALLED.

OTHER INSTRUCTIONS _____

Note: NJ State Law (P.L.2007, CHAPTER 57) requires every student with an EpiPen order to have a delegate assigned to him/her unless the HCP and/or parent/guardian feel(s)-that it is not indicated. Please indicate your preference:

- Delegate required Delegate NOT required

*****PLEASE NOTE: DELEGATES ARE NOT PERMITTED TO ADMINISTER AN ANTIHISTAMINE.*****

If the nurse is not available, do you want the antihistamine order to be omitted and have the delegate administer epinephrine as indicated above? YES NO

This student has been trained and is authorized to self-administer and carry the following medication(s).

- epinephrine – single dose unit antihistamine – single dose unit

This student is not authorized to self-administer the medication(s) named above.

Physician's Signature _____ Phone # _____

Date _____

Physician's Stamp _____