

HEALTH OFFICE

315 Hillside Avenue Demarest, New Jersey 07627

201 768-7822 ext. 218 201 767-2394 FAX healthoffice@holyangels.org

www.holyangels.org

EMERGENCY HEALT	TH CARE PLAN FOR :		DOB	HR
	<u></u>			
ASTHMA:YES				Student ID Picture:
	BLE FOR PROVISION OF ALL ME ACEMENT OF MEDS IF USED OR		H OFFICE,	
	CATION WILL BE ADMINISTERI TIVATED TO PROVIDE TRANSI			
1. If ingestion/expos	sure is suspected, give Epinephrine vi	a Auto-Injector:	Dosage	
2. Will second dose	of Epinephrine via Auto-Injector be	Required : NO _	YES Dosag	Timing
3. Will follow up On	ral Diphenhydramine be Required: N	O YES_	Dosage	Timing
4. Will inhaler/brond	chodilator be required: NO YE	.S 7	Type & Dosage_	
Side Effects:	ADDITI	ONAL INFO :		=======================================
Student has been instructed	ed on self-administration and will be r	esponsible to car	rry this medication	on with them at all times.
Physician Signature	Date			
		:	PHYSICIAN	N STAMP
Parent Name	Parent Signature	Tel#	6	DATE
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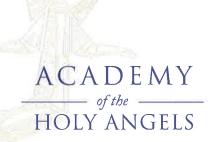
## AUTHORIZATION TO ADMINISTER EMERGENCY EPINEPHRINE VIA AN AUTO-INJECTOR. PART A: TO BE COMPLETED BY PARENT/GUARDIAN

I authorize the non-public School Nurse/principal/administrator to contact my primary health care provider on any questions related to my child's care. I also authorize the non-public School Nurse, or other unlicensed assistive individual educated by the nurse( Designated Emergency Responder ), to administer Emergency Epinephrine via an Auto-Injector to my child during regular school hours and at other times when my child is participating in a school related event. I authorize my child to engage in self-administration. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication, and that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, School Nurse and other school employees against any claims arising from the administration of this medication to my child.

Signature	Date
PART B: TO BE COMPLETED BY PI	RESCRIBING HEALTH CARE PROVIDER
Name of Student	Diagnosis
Name of Medication	
Dosage	
Frequency and Directions	
Description of Procedure	
Side Effects	
This Student has been instructed in self-adm school nurse and/or Emergency Responders will administer this medication.	ninistration. If unable to self-administer, the s who have been instructed in proper usage,
Signature	Date
Address	Tel







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## ACKNOWLEDGEMENT FORM SCHOOL ADMINISTRATION POLICY ON EPINEPHRINE NURSE, STUDENT, AND TRAINED DESIGNATED INDIVIDUALS (Designated Responders)

- 1. I have read the School Administration Policy on Epinephrine. I understand and acknowledge that AHA offers the administration of Epinephrine by the student who is capable of self-administration, the School Nurse, and Designated Responders.
- 2. I understand and acknowledge that the School Nurse is present M-F, from 8 AM to 2 PM. and that this schedule is subject to change.
- 3. I understand and acknowledge that my child is able and will be self-administering emergency Epinephrine.
- 4. I understand and am aware that if my child is unable to self-administer the Epinephrine, that the School Nurse will do so. In the event of the Nurse's absence, Designated Emergency Responders will carry out the administration of Epinephrine.
- 5. I understand that I am responsible to ensure that my child has this Emergency Medication with her at all times during regular school hours and at other times when my child is participating in a school related event.
- 6. If a situation arises where my child is not able to self-administer the medication and the School Nurse and Emergency Responders are not present, no other individual may provide the epinephrine and the EMS (911) will be activated. At this time, my child will be transported to the nearest medical health care facility.
- 7. I understand that the school, school nurse, and Designated Emergency Responders shall incur no liability as a result of any injury arising from administration of this medication and that I will indemnify and hold harmless all persons against claims arising from administration of this medication to my child.

PARENT/GUARDIAN SIGNATURE	DATE	
PRINCIPAL SIGNATURE	DATE	
SCHOOL NURSE SIGNATURE	DATE	
Student NamePlease Print	HR	



