The Montessori House

Pre-School for Discovery and Growth *426 Knickerbocker at Riveredge Rd.*
Telephone: (201)816-8343 Fax: (201) 816-8313 *Tenafly, NJ 07670*

Parent/Guardian Authorization for Administration of Epinephrine by Auto Injector Mechanism

Student _____ Date of Birth: _____

School Year: _____ (and for the summer program preceding or following the school year)

1. I am the parent/legal guardian of the above-named student.

2. My child has a potentially life-threatening allergy that could result in anaphylaxis. I request the emergency administration of epinephrine by use of an auto-injector mechanism or EpiPen, in the event of an anaphylactic reaction. My child does not have the capability for self-administration of the medication.

3. I acknowledge that The Montessori House School ("School") does not have an onsite school nurse, and I I consent to the administration of the EpiPen to my child for anaphylaxis by designated individual (an employe of the school trained in administration of an epinephrine auto-injector). If a designated individual is not present when the child experiences a severe allergic reaction, the School will call 911 and the student may be transported to a health care facility.

4. I acknowledge my understanding that the School and its employees and agents shall not be liable as a result of injury arising from the administration of the EpiPen to my child and that I shall indemnify and hold the School and its employees and agents harmless against any claims arising out of the administration of the EpiPen to my child.

5. I understand that as a condition of the School granting this request, I must provide to the School a written order signed by my child's physician certifying that my child requires the administration of epinephrine for anaphylaxis (*The Montessori House School Allergy and Anaphylaxis Emergency Plan*) and a copy of the child's prescription from the physician for the medication.

6. I understand that I must bring to the School two (2) current, physician-prescribed, pre-filled auto-injector mechanisms containing epinephrine.

7. I understand that I am responsible for replacing the medication when it expires or when otherwise necessary. I agree to pick up any unused medication at the end of the school year, when the medication becomes outdated, or when the medication is no longer necessary, whichever comes first.

8. I acknowledge that I have been informed that permission for administration of the medication will be effective only for the school year in which it is granted but may be renewed by the School for each subsequent school year upon fulfillment of the requirements set forth in this form in accordance with the School's policy on the administration of medication.

9. I authorize the School to contact my child's primary health care provider on any questions related to my child's care.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

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The Montessori House

Allergy and Anaphylaxis Emergency Plan

Child's name: _____Date of birth: _____

Date of plan: _____

Child has allergy to:

_____

Child has had anaphylaxis. ☐ Yes ☐ No

IMPORTANT REMINDER Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for	**Give epinephrine! What to do**
If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**. • Shortness of breath, wheezing, or coughing, *infants – nasal flaring* • Skin color is pale or has a bluish color • Weak pulse, *infants – unexplained fast heart rate* • Fainting or dizziness, *infants – limp, floppy* • Tight or hoarse throat, *infants – hoarse cry* • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many hives or redness over body • Feeling of "doom," confusion, altered consciousness, or agitation, *infants – inconsolable crying, decreased activity* ☐**SPECIAL SITUATION**: If this box is checked and initialed below by physician, child has an extremely severe allergy to an insect sting or the following food(s): _____ Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**. Physician Initials: _____	1. Give epinephrine right away! Note time when epinephrine was given. 2. Call 911. • Ask for ambulance with epinephrine. • Tell rescue squad when epinephrine was given. 3. Stay with child and: • Call parents and child's doctor. • Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Do not use other medicine in place of epinephrine.

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Allergy and Anaphylaxis Emergency Plan

For Mild Allergic Reaction What to look for	**Monitor child What to do**
If child has had any mild symptoms, **monitor child.** Symptoms may include: • Itchy nose, sneezing, itchy mouth, *infants – repeated lip licking*, *tongue thrusting, ear pulling* • A few hives • Mild stomach nausea or discomfort, *infants – spitting up more than usual, hiccups, back arching, pulling knees to chest*	Stay with child and: • Watch child closely. • Call parents and child's doctor. • If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Epinephrine Injector Details

Name of Medication: _____

Dosage: _____

Frequency & Directions: _____

Purpose: _____

Possible Side Effects _____

Appropriate for Delegation to UAP (unlicensed assistive personnel): ____ YES ____ NO (must be checked)

As Medical Provider of the above-named child, it is, in my professional opinion appropriate and necessary that the above medications be available for administration during the school day or during extended hours when the child is on school sponsored trips/outings/events.

Physician Name: _____

Physician Signature Authorization: _____

Date:_____ Physician Phone Number: _____

Parent Name: _____

Parent Signature Authorization: _____

Date: _____