CAMDEN CITY SCHOOL DISTRICT
HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's Name_____Grade/Teacher/HmRm _____

The above student is allergic to: _____

Asthmatic ___ Yes ___ No

MEDICATIONS

PLEASE NOTE: The School Nurse by law may administer any medication with physician's orders and parental consent, but trained non-medical designees, who may give emergency treatment in the School Nurse's absence, are NOT permitted by law to administer any medications other than epinephrine via auto-injector mechanism.

EPINEPHRINE: ___ EpiPen ___ EpiPen Jr. ___Other _____

School Nurse or designee: Give epinephrine for the following checked symptoms:

___ Contact with allergen, but no 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, call 911, parent, and healthcare provider.

ANTIHISTAMINE: Medication _____ Dose _____

School Nurse only: Give antihistamine for the following checked symptoms:

___ Contact with allergen, but no 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 _____

OTHER INSTRUCTIONS _____

___ This student has been trained and is authorized to self-administer the following medication(s) named above. ___ epinephrine – single dose unit ___ antihistamine – single dose unit

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

Healthcare Provider's signature _____Healthcare Provider's phone # _____

Date_____ Healthcare Provider's Stamp _____