



Dear Calvary Academy Parents and Guardians,

If your Child has a serious, life-threatening allergy and your Doctor has ordered Epinephrine via a pre-filled auto-injector mechanism (commonly known as EpiPen or Auvi-Q) and, or oral antihistamine medications and you would like these medications available to your child in school **please provide the EpiPen FARE two page form completed by you and your Doctor AND the following consent form. Please find BOTH forms below.** Prior to signing the following consent please also become aware of the following:

1. If the procedures specified in N.J.S.S. 18: a: 40-12.5 And 12.6 are followed, and the procedures in the "Protocol and implementation Plan for Emergency Administration of Epinephrine by a Delegate Trained by the School nurse" are followed Calvary Academy as well as its employees or agents, shall have no liability as a result of any injury arising from the administration of an epinephrine auto injector to the student.
2. The School nurse shall have the primary responsibility for the administration of epinephrine.
3. In the Nurse's absence a delegate will be assigned and approved as per your written consent to administer epinephrine auto-injector.
4. It is the Parent/guardian's responsibility to provide a current epinephrine auto-injector, Physician's orders (completed FARE form) and written consent. Permission and Physician's orders are effective only for the school year for which they are granted and must be renewed each subsequent school year.
5. It is the parent/guardian's responsibility to provide a current epinephrine auto-injector and future replacements as needed.
6. I will determine if the designated person has been properly trained by the school nurse using the Protocol and Implementation Plan established by the Department of Education.
7. After the epinephrine auto-injector administration, the designee will call "911" to transport the pupil to the hospital.

**In signing the following consent please become aware I have reviewed with you the liability issues regarding epinephrine administration during school hours/events in this letter and you may consult with our school nurse, with any other questions you may have.**

Serving Him,

Stephanie Cruz  
Principal



CONSENT FOR ADMINISTRATION OF EPINEPHRINE VIA AUTO-INJECTOR  
BY A DELEGATE

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

If the procedures specified in N.J.S.S. 18a:40-12.5 AND 12.6 are followed, and the procedures in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, \_\_\_\_\_ shall have no liability as a result of any injury arising from the administration of an epinephrine auto-injector to the student.  
(school name)

The parent/guardian shall indemnify and hold harmless the district or school and its employees against any claims arising out of the administration of the administration of the epinephrine auto-injector or the student.

It is the parent/guardian's responsibility to provide a current epinephrine auto-injector. Permission and physician's order are effective only for the school year for which they are granted and must be renewed each subsequent school year.

Reviewed with parent/guardian by Stephanie Cruz Date \_\_\_\_\_  
Signature

**Parent/Guardian Statement:**

1. In the event of a potentially life-threatening allergic reaction, as described in the attached physician's order, I authorize the emergency administration of epinephrine via auto-injector to my child \_\_\_\_\_ by the school nurse or by the delegate \_\_\_\_\_, who is properly trained according to the Protocol and Implementation Plan.
2. I understand that the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration by a Delegate Trained by the School Nurse" are followed by \_\_\_\_\_, as well as its employees or agents, shall have not liability as a result of any injury arising from the administration of the epinephrine auto-injector to my child.  
(School Name)
3. I indemnify and hold harmless \_\_\_\_\_ as well as its employees and agents, against any claims arising out of the administration of an epinephrine auto-injector to my child.  
(School Nurse)
4. I will provide a current epinephrine auto-injector to the school, and will replace it with a new one at least 2 weeks before it expires.
5. I understand my permission is granted only for this \_\_\_\_\_ school year.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Relation to student \_\_\_\_\_



PLACE  
STUDENT'S  
PICTURE  
HERE

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs.

Asthma:  Yes (higher risk for a severe reaction)  No

**For a suspected or active food allergy reaction:**

FOR ANY OF THE FOLLOWING  
**SEVERE SYMPTOMS**

If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.



**LUNG**

Short of breath, wheezing, repetitive cough



**HEART**

Pale, blue, faint, weak pulse, dizzy



**THROAT**

Tight, hoarse, trouble breathing/ swallowing



**MOUTH**

Significant swelling of the tongue and/or lips



**SKIN**

Many hives over body, widespread redness



**GUT**

Repetitive vomiting or severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of mild or severe symptoms from different body areas.

**NOTE:** Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Request ambulance with epinephrine.
  - Consider giving additional medications (following or with the epinephrine):
    - » Antihistamine
    - » Inhaler (bronchodilator) if asthma
  - Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

**NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.**

**MILD SYMPTOMS**

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.



**NOSE**

Itchy/runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea/discomfort



- 1. GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
- Stay with student; alert emergency contacts.
- Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

**MEDICATIONS/DOSES**

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

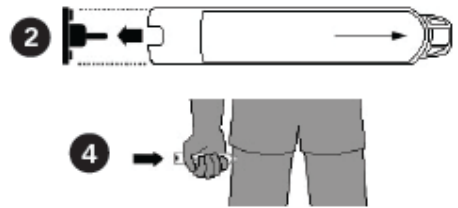
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



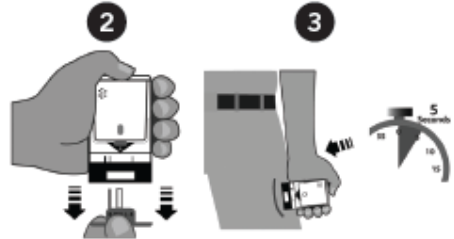
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



**ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE