



## **Administration of Epinephrine to a Student by a Delegate**

In accordance with New Jersey Law P.L 2007, Chapter 7, the Mount Laurel Township Board of Education policy on the administration of medication to a pupil provides that the school nurse shall have the primary responsibility for the administration of epinephrine. The school nurse shall designate, in consultation with the Board of Education additional employees of the school district who volunteer to administer epinephrine via a pre filled auto-injector mechanism to a pupil for anaphylaxis when the nurse is not physically present at the scene. The school nurse shall determine that:

- a. The designees have been properly trained in the administration of the epinephrine via a pre-filled auto injector mechanism.
- b. The parents or guardians of the pupil consent in writing to the administration of the epinephrine by a designee.
- c. The Board of Education shall inform the parents or guardians of the student in writing that the district and its employees shall have no liability as a result of any injury arising from the administration of the epinephrine to the student.
- d. The parents or guardians of the student sign a statement acknowledging their understanding that the district shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector to a student and that the parents or guardians shall indemnify and hold harmless the district and its employees any claims arising out of the administration of the epinephrine to a student.
- e. The permission is effective for the school year for which it is granted and must be renewed for each subsequent school year.

**The permission form on the reverse side is for permission for a delegate to administer epinephrine via auto-injector to the designated student. There is a separate form that must be completed to allow the school nurse or her substitute to administer the epinephrine.** This second form allowing the nurse to administer the epinephrine also allows for administration of an antihistamine, if so ordered by a physician and approved by the parent/guardian. A delegate **MAY NOT** administer an antihistamine (i.e. Benadryl).

Medications must be brought to school in the original labeled pharmacy container by an adult. The epinephrine auto-injectors will be stored in a secure unlocked location, easily accessible to the nurse and school delegates while school is in session and during school sponsored functions.

**\*\*SEE REVERSE SIDE FOR DELEGATE PERMISSION FORM\*\***

# Medication Permission for Administration of Epinephrine by a Delegate

**\*\*Please note that a delegate may *NOT* give an antihistamine, therefore the physician's order must note the specific symptoms and/or events (i.e. ingestion of peanut) as to when the delegate should administer the epinephrine\*\***

School Year \_\_\_\_\_

Class \_\_\_\_\_

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

Student is allergic to: \_\_\_\_\_

Student is asthmatic: \_\_\_\_ Yes \_\_\_\_ No

**Check off the appropriate times the delegate should administer epinephrine in the dose indicated below.** (This must be completed for delegate order to be in effect.)

\_\_\_\_ If a food allergen has been ingested, but no symptoms. Name the allergen(s):  
\_\_\_\_\_

\_\_\_\_ If stung or bitten by an insect, but no symptoms. Name the allergen(s):  
\_\_\_\_\_

\_\_\_\_ Mouth: itching, tingling, swelling of lips, tongue, mouth

\_\_\_\_ Skin: hives, itchy rash, swelling of the face and/or extremities

\_\_\_\_ Throat: tightening of throat, hoarseness, hacking cough

\_\_\_\_ Gut: nausea, abdominal cramps, vomiting, diarrhea

\_\_\_\_ Lung: shortness of breath, repetitive coughing, wheezing

\_\_\_\_ Heart: thready pulse, fainting, pale, blueness

\_\_\_\_ Other: \_\_\_\_\_

Epinephrine (Brand/Dose) \_\_\_\_\_

Possible side effects: \_\_\_\_\_

After administration of epinephrine, the delegate will: call 911 and monitor patient until EMS arrives.

\_\_\_\_\_  
**NAME OF PHYSICIAN (PRINTED)**

\_\_\_\_\_  
**SIGNATURE OF PHYSICIAN**

\_\_\_\_\_  
**TELEPHONE NUMBER OF PHYSICIAN**

\_\_\_\_\_  
**DATE**

**I hereby give permission for my child's delegate(s) to administer the above medication to my child named above. I shall provide this medication in its original container, properly labeled from the pharmacy/store. I release the Mt. Laurel Township Board of Education and its employees from any liability concerning the administration of such medication to my child.**

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**