"Excellence Through Diversity"

ENGLEWOOD PUBLIC SCHOOLS

Dwight Morrow High School and The Academies @ Englewood

274 Knickerbocker Road Englewood, New Jersey 07631
Health Office
T: 201- 862-604 Fax: 201-833-1996
E-mail: bmanche@epsd.org
Barbara Manche RN
Certified School Nurse

Student's Name ____________________________ DOB__________Date____________

TO BE COMPLETED BY PHYSICIAN:

- ☐ If stung by ____
- ☐ After ingesting ____
- ☐ After exposure to ____
- ☐ Immediately give ____________________whether or not symptoms are present.
  medication/dose/route

☐ ***Student is allowed to carry and self administrate one dose of benadryl*** (physician must check). **After self administration of benadryl, student must see nurse.**

Observe student for up to 30 minutes.

____	MOUTH:	itching and/or swelling of lips, tongue, or mouth.
____	THROAT:	itching and/or sense of tightness in throat, hoarseness, hacking cough, and/or difficulty swallowing.
____	SKIN:	itching, hives, rash, and/or swelling in any area of body.
____	ABD:	nausea, abdominal cramps, vomiting, and/or diarrhea.
____	LUNG:	shortness of breath, sense of tightness in chest, repetitive coughing, and/or wheezing.
____	HEART:	rapid weak pulse, dizziness and/or fainting.
____	OTHER:	____
		____

☐ **If symptoms become more severe, as noted above, give:**

____. If Epi-pen is administered, 911 must be called and student must be transported to the Emergency Room.

STUDENT HAS HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS: ___☐Yes ___☐ No

IF EPINEPHRINE AUTO-INJECTOR IS PRESCRIBED, CHECK ONE:

____ **Student is not capable of self-administration.**

____ **Student is capable of self-administration and has been instructed in its use and may carry epinephrine auto-injector with him/her.**

If epinephrine is given, EMS will be immediately contacted.

Physician's Signature: ____________________________________ Date: ______________

Please print or stamp Name: ______________________________

Address: ______________________________

Phone: ____________________________________

PARENTS/GUARDIANS MUST COMPLETE AND SIGN SECOND PAGE

TO BE COMPLETE BY PARENT/GUARDIAN:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the physician.

Parent/Guardian Signature: ________________________________

Date: __________________

Home Phone: ____________________________

Emergency Phone: ___________________________