



"Excellence Through Diversity"

ENGLEWOOD PUBLIC SCHOOLS
Dwight Morrow High School and The Academies @ Englewood
274 Knickerbocker Road Englewood, New Jersey 07631
Health Office

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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: _____