Galloway Township Public Schools
101 South Reeds Road
Galloway, NJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

ALLERGIC/ANAPHYLACTIC REACTION QUESTIONNAIRE/ACTION PLAN

Dear Parent/Guardian:

You have informed the school nurse that your child experiences an allergic/anaphylactic reaction due to an allergen. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the current school year.**

Student's Name: _____ Grade: _____ Date of Birth: _____

MEDICAL HISTORY: (To be completed by parent/guardian and physician)

Briefly describe what causes the child's allergic/anaphylactic reaction: _____
_____

What are his/her signs and symptoms of the reaction? _____
_____

How soon do the signs and symptoms appear after the child is exposed to the allergen? _____
_____

EMERGENCY PHONE NUMBERS:

Mother: Home_____Work_____
Father: Home_____ Work_____
Other: Name_____Relationship _____
Home_____ ___Work _____
Preferred hospital_____

I understand that this information may be shared with appropriate staff members having contact with my child.

_____ _____
Parent's/Guardian's Signature Date

OVER>>>>>

"Where Children and Learning Come First"

Student's Name: _____ Grade: _____ Date of Birth: _____

PHYSICIAN PERMISSION TO ADMINISTER MEDICATON
TO BE COMPLETED BY PHYSICIAN

EMERGENCY PROCEDURES:

List the actions that are to be taken for this child for an allergic/anaphylactic reaction:

1. _____
2. _____
3. _____

MEDICATION ORDER:

Name of medication_____

Dosage _____ Route _____Time _____

Frequency _____Indications for use_____

Side effects _____

Duration of order _____

May withhold does for field trips (Teachers are not in attendance on field trips to administer medication and teachers are not permitted to administer medication): _____YES _____ NO

Parent/Guardian will accompany child on field trip to administer medication: _____YES _____NO

List other medications child is on which may enhance, alter or impact this medication _____

_____

Is capable of and may self-administer this medication? _____ YES _____NO

_____ _____

Physician/Health Care Provider's Signature/Stamp Date

_____

Please Print Physician/Health Care Provider's Name, Address, and Phone Number

PARENT PERMISSION TO ADMINISTER MEDICATION

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side this form and as per the policy of the Galloway Township Board of Education and State law.

_____ _____ _____

Parent's/Guardian's Signature Date Phone Number

PUPIL SELF ADMINISTRATION OF MEDICATION PERMISSION

The Board of Education shall permit self administration of medication for **asthma or other potentially life threatening illnesses** by pupils in grades 1 through 8, both on school premises during regular school hours and off site or after regular school hours when a pupil is participating in field trips or extracurricular activities and the school nurse and his/her designee is not present.

My child, _____ has my permission to administer his/her own medication _____ for **asthma or other potentially life-threatening illnesses** both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. I acknowledge that the Galloway Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and it's employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____

Parent's/Guardian's Signature Date

In the absence of the school nurse, I grant permission for a trained delegate to administer my child's epi-pen as medically ordered. I understand that if the specified procedures are followed, the district, its employees and agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child.

_____ _____

Parent's/Guardian's Signature Date