



*Galloway Township Public Schools*

101 South Reeds Road | Galloway, NJ 08205

Phone: (609) 748-1250 | Web: [www.gtps.k12-nj.us](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 MEDICATION  
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 \_\_\_\_\_

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

Parent/Guardian will accompany child on field trip to administer medication: \_\_\_\_\_ YES \_\_\_\_\_ NO

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 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

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

**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 its employees or agents against any claims arising out of self-administration of medication by my child.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date