



Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE
PICTURE
HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

☐ Patient may self-carry ☐ Patient may self-administer

1. **ADMINISTER EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2025

*****Please see other side for more information and signatures.*****

IHGS AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE AUTO-INJECTOR AT SCHOOL

Student Name: _____

DOB: _____

Grade: _____

Emergency Contacts:

Name: _____

Phone: _____

Name: _____

Phone: _____

I. Parental/Guardian Consent for Delegate Administration of Epinephrine Auto Injector I hereby acknowledge my understanding that if the procedures outlines in P.L. 2007, c.57 and "TRAINING PROTOCOLS FOR THE EMERGENCY ADMINISTRATION OF EPINEPHRINE " issued by the NJ Department of Education are followed, the school district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto injector containing epinephrine and the parent/guardian shall indemnify and hold harmless the school district and its employees or agents against any claims arising from the administration of a pre-filled single dose auto injector containing epinephrine to the student. The school nurse shall designate, in consultation with the Board of Education, additional employees of the school district to administer epinephrine via auto-injector to my child for anaphylaxis or possible anaphylaxis when the school nurse is not physically presents at the scene, as specified in P.L. 2007, c.57.

____ I approve having delegate(s) assigned for my child.

____ I decline delegate administration of epinephrine for my child

Parent/Guardian Name_____
Signature_____
Date

II. Parental/Guardian Consent for Student Self Administration of Epinephrine Auto Injector (appropriate for older children only)

____ I request that my child be ALLOWED to carry the prescribed medication for self-administration in school and on off-site school related activities pursuant to N.J.S.A.:18A:40-12.3-12.6. I give permission for my child to self-administer medication, as prescribed on this form for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

____ I do not allow my child to carry and self-administer epinephrine auto- injector.

Parent/Guardian Name_____
Signature_____
Date

III. Healthcare Provider's Order (please check all applicable lines)

The above student has a potentially life threatening allergy that could result in anaphylaxis and

The Student's potential triggers of Anaphylaxis are: _____

The Student is an Asthmatic _____ Yes _____ No

The Student's possible symptoms of Anaphylaxis are:

Or _____ possible symptoms are unknown at this time but student is at risk for future anaphylaxis.

In case of possible anaphylaxis administer:

____ Epinephrine auto-injector 0.3mg up to 2 doses as needed

____ Epinephrine auto-injector 0.15mg up to 2 doses as needed

____ School nurse may administer a single oral dose of Diphenhydramine: _____mg

____ Student may self-administer epinephrine auto-injector as prescribed above. This student has been instructed in and is capable of proper method of self-administration of epinephrine auto-injector. This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____ This student is not approved to self-medicate with an epinephrine auto-injector.

Physician/APN Name_____
Signature_____
Date

Physician's Office Stamp:

Accepted by School Nurse _____ Initials _____ Date