

PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's Name _____ Birth Date _____ Grade/Teacher _____

The above student is allergic to: _____

Previous episode of anaphylaxis Yes No

MEDICATIONS

ANTIHISTAMINE: Name _____ Dose _____

Give antihistamine for the following checked symptoms:

- Contact with allergen, but no symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Gut – abdominal cramps, nausea, vomiting, diarrhea
- Lungs – repetitive cough, wheezing, shortness of breath
- Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- Other _____

EPINEPHRINE: EpiPen EpiPen Jr. Other _____

Give epinephrine for the following checked symptoms:

- Contact with allergen, but no symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Gut – abdominal cramps, nausea, vomiting, diarrhea
- Lungs – repetitive cough, wheezing, shortness of breath
- Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- Other _____

Choose one administration order:

Give Antihistamine only

Give epinephrine only * Delegate will be assigned

Give Antihistamine & Epinephrine at same time * Delegate will be assigned

Give Antihistamine first, observe for further symptoms and give epinephrine PRN

***Please note – in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

- This student has been trained and is capable of self-administration of the following medication(s)
 - Epinephrine – single dose unit
 - Epinephrine & Antihistamine – single dose units

*Under NJ state law, orders for antihistamine alone cannot be self-administered

This student is not capable of self-administration of the medications named above.

Date _____

Physician's Signature _____

Phone number _____

Stamp _____

