BERLIN TOWNSHIP SCHOOL DISTRICT
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 ☐*Delegate will be assigned

***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) named above. ☐ 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.

Physician's signature _____

Phone number _____

Date_____ Stamp _____ ***(over)***