MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Student's Name: _____Date of Birth: _____
(Please Print)

Gender: Male / Female (circle one)

My child previously attended a Montgomery Twp. School? Yes / No (circle one)

If yes, circle last school attended OHES VES LMS UMS MHS

HEALTH HISTORY

Has Your Child Had:	NO	YES	YEAR
Chicken Pox			
Heart Problems			
Kidney Problems			
Bladder Problems			
Asthma			
Bronchitis			
Strep Infection			
Mononucleosis			
Diabetes			
Convulsions			
Hepatitis			
Rheumatic Fever			
Pneumonia			

Does your Child Have:	YES/TYPE	NO
Congenital Defects		
Drug Sensitivities		
Neuromuscular Disease		
Speech Problems		
Vision Problems		
Eyeglasses		
Hearing Problems		

Has your child had:	If yes, description and date.
Any severe injury?	
Any operations?	

Initial the statement that applies to your child:

_____My child does **not** have a life-threatening allergy requiring the use of epinephrine.

_____My child has a life-threatening allergy requiring the use of epinephrine.
Please complete the Life-Threatening Allergy Questionnaire on the following page.

Parent/Guardian Signature: _____Date: _____

Life-Threatening Allergy Questionnaire

Complete this form only if your child has a life-threatening allergy and is entering grades:
Pre-K, Kindergarten - 4

Student's Name: _____ For School Year: _____

Date of Birth: _____ My Child will be in the following grade during the School Year indicated above: ____

1. **List only life-threatening allergens (food and non-food):**

   _____

2. **Does your child have a prescribed epinephrine auto-injector? ☐ Yes* ☐ No**
   **A health care provider completed Montgomery Township School District Emergency Allergy Action Plan (EAAP) is required if your child has a life-threatening allergy indicating the use of epinephrine in school. This EAAP and other forms can be obtained through your child's school nurse. Forms must be renewed every school year.*

3. **Will your child carry an epinephrine auto-injector in their backpack in addition to the one kept in the health office? ☐ Yes* ☐ No** *Refer to the 'Capacity for self-administration of epinephrine' section on the EAAP for an explanation of carrying options. *Your child's health care provider must check either the 1st or 2nd option for authorization to carry. Please note, if your child carries a set of epinephrine auto-injectors in their backpack, you must also provide another set to keep in the health office for emergency use during the school day.*

4. **Regarding lunch, check only one option (questions 4 & 5 applicable only for grades 1-4)**
   ☐ **My child may purchase school-prepared lunch.** *Parents should review the Chartwell menu in advance of a student's purchase. Refer to the OHES or VES websites under 'Lunch Menu" selection for more information. School and cafeteria staff will not make any determination of food safety as related to life-threatening allergies. Food allergen questions should be directed to Ms. Pat Kurczewski, Director of Dining Services, at 609-466-7602 ext 6510, or via email at chartwells@mtsd.us*

   ☐ **My child is not allowed to purchase school-prepared lunch; I will provide daily lunch from home.**

5. **During lunch, my child must* sit at: (check only one)**
   ☐ **No seating restriction** ☐ **Nut-free table** ☐ **Nut & liquid dairy-free table**
   *Students with a completed EAAP, current for the school year, are allowed to sit at the nut & dairy- free tables. The lunchroom aides are informed of students with life-threatening allergies & will monitor for compliance. *If 'No seating restriction' is checked, and your child has an EAAP, they may sit at one of the nut & dairy- free tables whenever desired. If you check one of the nut & liquid dairy-free tables, your child will be required to sit at that assigned table. Please contact your child's school nurse if you want to change your child's cafeteria seating during the year.*

6. **Does your child have asthma? ☐ Yes ☐ No**
   a. **If yes, will you provide an inhaler to keep at school? ☐ Yes* ☐ No**
   ** As per: N.J.S.A. 18A:40-12.8, a health care provider completed NJ Asthma Treatment Plan is required if your child uses an inhaler during school, even if they are not diagnosed with asthma. See school nurse for this form.*

Parent/Guardian Signature: _____ **Date:** _____

The following to be completed by School Nurse:

IHP completed: ☐ Yes ☐ No IHP signed by parent: ☐ Yes ☐ No	Epinephrine received : ☐ Yes ☐ No EAAP received: ☐ Yes ☐ No	Genesis/Cafe note updated: ☐ Yes ☐ No Transportation notified: ☐ Yes ☐ No

Notes _____

Montgomery Township School District

EMERGENCY ALLERGY ACTION PLAN

School Year: _____

Photo Here

Student Name: _____ Date of Birth: _____

Allergic to (list allergens that may cause anaphylaxis):

_____

Teacher: _____ Home Room: _____ Grade: _____

Healthcare Provider- Complete, Initial Capacity Statements, Sign, Date, & Stamp:

Current Weight: _____ Epinephrine Auto-Injector Dose: ☐ 0.15 mg (Jr) ☐ 0.3 mg (Adult)

Antihistamine (drug/dose): _____

History of Asthma or Reactive Airway: ☐ No ☐ Yes Bronchodilator (drug/dose): _____

Capacity for self-administration of epinephrine (Healthcare provider- initial box next to applicable statement(s):
You may select a combination of options. If for any reason the student cannot self-administer, the school nurse, or delegate will give epinephrine. Delegates are not authorized by NJDOE to administer antihistamines or bronchodilators.

Office Stamp

☐ Student will carry and self-administer epinephrine.

☐ Student will carry, but cannot self-administer.

☐ Student's epinephrine is kept in the health office for administration by the school nurse or delegate.

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian- Review Statements, Sign, Date, & Complete:

**Each school year, you must provide the school nurse with all unexpired emergency medication(s) ordered by your child's healthcare provider along with an updated Emergency Allergy Action Plan. Your child will not be permitted to participate in athletics, day or overnight off-campus trips, and school sponsored events without their medication(s), and an Emergency Allergy Action Plan on file in the health office.*

I understand that in the event of an anaphylactic emergency, epinephrine will be administered to my child by a school nurse or delegate as indicated in this Emergency Allergy Action Plan. My signature indicates acknowledgement that the Montgomery Township School District, and its employees or agents, shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto injector mechanism.

Parent/Guardian Signature:_____ **Date:** _____

Parent/Guardian/Emergency Contact Information: Please **print** legibly all contact names and phone numbers in order of priority.

1._____
Name (print clearly) Preferred Phone Alternate Phone

2._____
Name (print clearly) Preferred Phone Alternate Phone

3._____
Name (print clearly) Preferred Phone Alternate Phone

↬**EPINEPHRINE ADMINISTRATION INSTRUCTIONS ON BACK OF FORM**↫

IDENTIFY SYMPTOMS → INJECT EPINEPHRINE → CALL 911

SEVERE SYMPTOMS

One or **more** of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, Blue, Faint, weak pulse, dizzy
THROAT:	Tight, hoarse, trouble swallowing or breathing
MOUTH:	Obstructive swelling (tongue and /or lips)
SKIN:	Many hives over body
GUT:	Vomiting, diarrhea, crampy pain
OTHER:	Anxiety, confusion, feeling of unease

Or a **Combination** of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. CALL 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/bronchodilator as ordered by HCP (only RNs may administer)*

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6. Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis)- **USE EPINEPHRINE**

If **MILD SYMPTOMS** From **MORE THAN ONE** Body System, **GIVE EPINEPHRINE**

For MILD SYMPTOMS From a SINGLE BODY SYSTEM

Nose:	Itchy or runny nose, sneezing
Mouth:	Itchy mouth / throat
Skin:	A few hives, mild itch
Gut:	Mild nausea / stomach ache

Give antihistamines as ordered by healthcare provider.

Stay with person; alert emergency contacts.

Watch closely for changes.

If symptoms worsen, give epinephrine & call 911

TO INJECT EPINEPHRINE:

1. REMOVE AUTO-INJECTOR FROM PROTECTIVE CASE
2. REMOVE ALL PROTECTIVE CAPS
3. GRASP AUTO-INJECTOR, SWING AND PUSH FIRMLY AGAINST MIDDLE OF OUTER THIGH HOLD FIRMLY IN PLACE FOR 3 SECONDS (COUNT SLOWLY)
4. REMOVE AND MASSAGE THE INJECTION SITE FOR 10 SECONDS.

Revised: 2020-12-10