www.greenhills.org

P.O. Box 14 • 69 Mackerley Road • Greendell, NJ 07839
Dr. Lydia Furnari, Interim Superintendent
Mr. Jon Paul Bollette, Principal

973-300-3800
Fax 973-300-0617

MEMO TO: Parents/Guardians of Students with Anaphylactic Allergies
FROM: Kerry Burneyko, RN
RE: Allergy Forms and Medication

Dear Parent/Guardian,

The attached forms are for any student with a potentially life-threatening allergy. Please review and complete the following documentation and return it to me as soon as possible, but no later than the first day of school.

Required Forms:

1. Anaphylaxis Action Plan – this needs to be completed by you *and* your medical provider. These are the medical orders the school nurse follows in the event of an allergic reaction.
2. Emergency Care Plan – you complete the top portion. With your permission, this form is shared with the school staff your child interacts with. It instructs them on what to do in an emergency.
3. Individual Health Care Plan – for your review and signature. This discusses nursing interventions.
4. Parent Authorizations – for your review & signature. Discusses cafeteria seating and class parties.
5. Green Township Food Allergy Waiver – for your review and signature. If you do not sign the waiver, please send in a box of treats that your child can have during a class party.

➤ **Parents ONLY need to complete the areas of the above-listed forms that are highlighted in PINK.**
➤ Original forms may be mailed or hand-delivered to the health office.

Medication:

1. Please ensure the medication(s) do/does not expire during the year.
2. Please bring the medication(s) in the original, labeled container/box to the School Health Office on the first day of school (or the two days prior).
3. Don't forget an unopened bottle of anti-histamine if it has been ordered.

➤ Medications may ONLY be accepted from the parent/guardian as per district policy.
➤ Students may not transport medications to/from school as per district policy.

Board of Education Policy for Treating Anaphylaxis:*

Please be advised that the Board Policy places primary responsibility for the administration of epinephrine via the Epi-Pen on the school nurse, as prescribed by your medical provider. However, because the school nurse is not always available and because of the emergency nature of anaphylaxis, the school nurse, in accordance with N.J.S.A. 18A:40-12-5 and 12-6, will train volunteer school employees in the administration of the Epi-Pen. *Only the school nurse may administer medication other than the Epi-pen.*
**For full details on the district's policies for responding to life-threatening allergies, please see Policies 5330 & 5331 on Greenhills.org.*

Thank you in advance for your cooperation! Our goal is a safe and fun-filled school year. Let's work together to keep your child safe from food allergens. Please reach out with any questions: 973-300-3800 x 215.

Yours in health,

Kerry Burneyko, RN, BSN, CSN

(BLANK)

TWO-STEP ALLERGY/ANAPHYLAXIS ACTION PLAN

Kerry Burneyko, RN, BSN, CSN ▿ Green Hills School ▿ P.O. Box 14 ▿ 69 Mackerley Road ▿ Greendell, NJ 07839 ▿ 973-300-3800 x 215 ▿ Fax 973-300-0617

Parent Completes

Student Name:	DOB:	Grade:
Allergy to:		Weight:
Symptoms (hives, difficulty breathing, etc):		
Asthmatic: ❒ Yes (Higher risk for severe reaction) ❒ No	Fam. hx. allergies:	
Date of Last Reaction:	Went to Hospital? ❒ Yes ❒ No ❒ n/a	

STEP ①: Treatment

To be completed by Physician

SYMPTOMS DISPLAYED	GIVE CHECKED MEDICATION (To be determined by physician)	
If a food allergen has been ingested, but no symptoms occur:	❒ epinephrine	❒ antihistamine
Mouth - itching, tingling, swelling of lips, tongue, mouth:	❒ epinephrine	❒ antihistamine
Skin - hives, itchy rash, swelling of the face or extremities:	❒ epinephrine	❒ antihistamine
Gut - nausea, abdominal cramps, vomiting, diarrhea:	❒ epinephrine	❒ antihistamine
Throat♦ - tightness of throat, hoarseness, hacking cough:	❒ epinephrine	❒ antihistamine
Lungs♦ - shortness of breath, repetitive coughing, wheezing:	❒ epinephrine	❒ antihistamine
Heart♦ - weak/thready pulse, low BP, fainting, pale/blueness:	❒ epinephrine	❒ antihistamine
Other (*fill in*):	❒ epinephrine	❒ antihistamine
If reaction is progressing (several of the above areas affected), give:	❒ epinephrine	❒ antihistamine

♦ = *Potentially life-threatening. Severity of symptoms can change quickly.*

Medication Dosage(s):* (✓ ONE)

Epinephrine:

❒ Epinephrine 0.15 mg IM

❒ Epinephrine 0.3 mg IM

If symptoms persist, repeat dose in _____ mins.

Antihistamine (med/dose/route): _____

_____

Other (med/dose/route): _____

_____

Medication Sequence:* (✓ ONE)

❒ Give epinephrine only

❒ Give antihistamine & epinephrine at same time

❒ Give antihistamine first, observe for further symptoms and give epinephrine only if needed.

* *If antihistamine and epinephrine are ordered, non-nurse delegates will skip the antihistamine and administer epinephrine immediately. Delegates may only administer epinephrine.*

Medication Self-Administration: † (✓ ONE)

This student has been trained and is capable of self-administration of:

❒ Epinephrine - single dose unit

❒ Epinephrine & antihistamine - single dose units

❒ This student is NOT capable of self-administration of the medications above.

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

Physician's Sig.: _____ Date: _____

Stamp of Physician: _____ Phone: _____

To Be Completed by Parent

Medication Self-Administration *(IF APPLICABLE. Usually for 7th or 8th graders)*:

I give permission for my child to SELF ADMINISTER the above-mentioned medication. I and my student assume responsibility to ensure that this medication is in his/her possession during school and prior to participating in any practice, event and/or field trip during the academic school day. The Green Hills School and its employees shall be held harmless against injury or claims that arise as a request of the pupil's self-administration of medication.

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

STEP ②: Emergency Calls

- Call 911. *State an allergic reaction has occurred, & additional epinephrine & advanced life support may be needed.*
- Call Parent(s):

Parent/Guard. 1 _____ Cell _____ W _____ H _____

Parent/Guard. 2 _____ Cell _____ W _____ H _____

If parent(s) unreachable, do not hesitate to medicate or have child transported via EMS to nearest emergency medical facility!

- Call emergency contacts if parent(s)/guardian(s) unreachable:

Emerg. Cntct. 1 _____ Cell _____ W _____ H _____

Emerg. Cntct. 2 _____ Cell _____ W _____ H _____

- Notify physician: _____

Parent/Guardian Authorizations:

I, _____, give permission for the administration of the prescribed medication as directed by the physician to my child _____. I also authorize delegates trained by the school nurse to administer the epinephrine if the school nurse is unavailable and the student is unable to self-administer. I understand that antihistamines may not be given by a delegate, and that *in the absence of the school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.*

I further acknowledge and understand the following:

- If the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, the district or nonpublic school shall have no liability as a result of any injury arising from the administration of a pre-filled, auto-injector mechanism containing epinephrine to the pupil and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of a pre-filled auto-injector mechanism containing epinephrine to the pupil.
- I will provide the school with the prescribed medication and will replace it when it is expired.
- I give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and the above-mentioned medications. In addition, I understand that this information will be shared with school staff and Classroom Parents on a need-to-know basis.
- This permission is effective for the school year for which it is granted and will be renewed for each subsequent school year upon fulfillment of the requirements stated in the N.J.S.A. 18A:40-12.6.

Parent/Guardian Signature: _____ Date: _____

Allergy Emergency Care Plan: For Teachers & Non-Medical Staff of Green Hills School

Parent Completes

Student: _____ DOB: _____ Grade: _____

Allergy to:_____ Asthmatic: ❒ Yes ❒ No Weight: _____

AM Select 1: ❒ Drop-off ❒ Bus # _____ ❒ "Before Care" **PM Select 1**: ❒ Pick-up ❒ Bus # ____ ❒ "After Care"

Parent/Guard. 1 _____ Cell _____ W _____ H _____

Parent/Guard. 2 _____ Cell _____ W _____ H _____

Emerg. Cntct. 1 _____ Cell _____ W _____ H _____

Emerg. Cntct. 2 _____ Cell _____ W _____ H _____

Physician Name: _____ Physician Phone: _____

Parent Signature: _____ Date: _____

STAFF ACTIONS DURING SEVERE ALLERGIC REACTION

SIGNS/SYMPTOMS	IF NURSE (or Delegate) IN BUILDING:	IF NURSE (or Delegate) UNAVAILABLE:
Epinephrine needed for ANY of these • Short of breath, wheezing, coughing • Pale, clammy, blue, faint, dizzy • Throat tightness, hoarse, trouble breathing/swallowing • Swelling of tongue and/or lips • Hives all over body; widespread redness • Severe vomiting or diarrhea • Sense of impending doom, anxiety, confusion	• Call the nurse (x 215) to come to the student. State: location, student name, allergic reaction. • Remain with and reassure student. • Nurse will administer medication(s). • In absence of Nurse, EpiPen Delegate will administer EpiPen ONLY, not Benadryl or other meds • If EpiPen is given, 911 will be called immediately and parent(s) contacted.	• Call 911, state student has allergic reaction and epinephrine and advanced life support are needed. • Notify Administrator & parent • Remain with and reassure student until paramedics arrive. • If breathing stops, CPR-certified staff gives CPR until EMS arrives. • A school staff should go in ambulance if guardian not present

STAFF ACTIONS DURING MILD ALLERGIC REACTION

SIGNS/SYMPTOMS	IF NURSE IN BUILDING:	IF NURSE UNAVAILABLE:
*More than 1 of these symptoms is a severe reaction; treat as above↑ • Itchy/runny nose, sneezing • Itchy mouth • A few hives, mild itching • Mild nausea/discomfort	• Stop activity immediately: *never ask an allergic student to wait until the end of a lesson or class.* • Send student to nurse with a buddy; *never send student alone!* • Nurse will assess and give meds. • Nurse will observe for relief of symptoms and contact parent and/or call 911 as needed.	• Notify Administrator and parent. • Parent/guardian (if available) may come to school to administer medication and/or take child home for care. • *If parent/guardian and emergency contacts cannot be reached and symptoms persist or worsen, do not hesitate to call 911.*

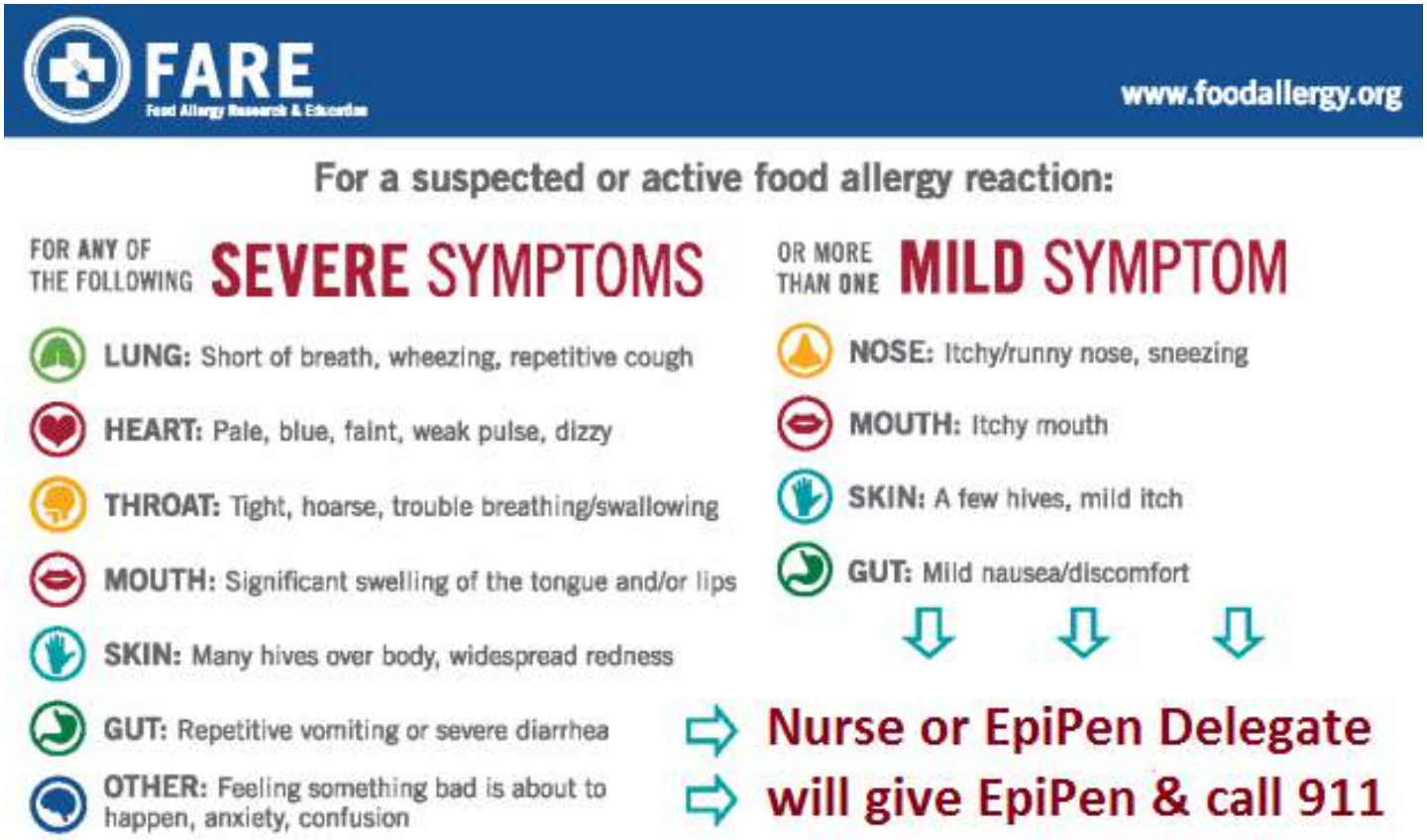
Bus Plan: (1) Pull over, (2) Call 911, (3) Stay with student, (4) Notify School, (5) Notify Parent

Epinephrine Dose: ❒ 0.15 mg ❒ 0.3 mg	Sits at Nut-free Lunch Table: ❒Yes ❒No	Med located: ❒ W/ student ❒ W/ Nurse

School Nurse Signature: _____ Date: _____

General Prevention Tips for Teachers/Staff:

- No sharing of food.
- Frequent hand-washing/cleaning of desks and countertops is important.
- Make teacher aides aware as needed.
- If the nurse is unavailable in an emergency, the list of staff certified as Epi-Pen Delegates is available in the Main Office.
- Be particularly vigilant on special days: field trips, parties, and other special events.
- Make Class Parents aware of food policies: no nuts in classrooms and only ***approved foods*** for class parties (Class Party Foods list can be obtained from School Nurse or GreenHills.org under "*Nursing Health Services*").
- Notify substitutes of student allergy and keep this ECP in your substitute folder.



Green Hills School ▿ 69 Mackerley Road ▿ Greendell, NJ 07839 ▿ 973-300-3800 x 215 ▿ Fax 973-300-0617

ANAPHYLAXIS INDIVIDUALIZED HEALTHCARE PLAN (page 1)

Parent Completes

Student Name: _____ DOB: _____ Grade: _____ Year Diagnosed: _____

Parent: I have reviewed the below plan and agree to its implementation.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL NURSE

ASSESSMENT	NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTIONS	STUDENT OUTCOME
Medical documentation of allergy to: _____ _____ _____ _____ Prescribed med(s): ❒ Antihistamine ❒ Epinephrine 0.15 mg IM ❒ Epinephrine 0.3 mg IM *(See Allergy Action Plan for full details.)* Baseline Vitals: BP: _____ Temp: _____ Pulse: _____ Resp: _____	☑ Potential for life threatening reaction related to ineffective airway clearance and decreased cardiac output. ☑ Potential for knowledge deficit r/t: ☑ Allergen ☑ Symptoms of allergic reaction ☑ ECP ☑ Effective therapeutic regimen management related to: ☑ Ability to seek help from others ❒ Ability to self-medicate (when appropriate)	☑ Avoid contact with allergen or source of anaphylactic reaction. ☑ Identify symptoms of allergic reaction. ☑ Participate in development and implementation of healthcare plan at school. ☑ Be safe in all school environments. ☑ Know when and how to seek help. ❒ Develop self-medication skills when appropriate. ☑ Prevent allergic reactions from occurring.	☑ Provide necessary health counseling opportunities for student to participate in self-care (depending on student's cognitive and/or physical ability) ☑ Review symptoms & sources of allergen(s). ☑ Review treatment methods, including how/when to seek assistance from school staff and classmates. ❒ Teach proper technique of self-administration of epinephrine (if indicated by parent & HCP). ☑ Monitor school environment for potential allergens and environmental triggers. Notify custodial staff as appropriate. ☑ Teach *all* students not to share food. ☑ Maintain current medical orders, consents, release of records and supply of medication. ☑ Ensure all school staff (including bus driver if appropriate) complete anaphylaxis in-service. ☑ Develop Emergency Care Plan with treatment guidelines (mild - severe). ☑ Identify and train volunteer staff for administration of EpiPen as EpiPen Delegate(s). ❒ If food allergen, ensure student brings lunch	☑ Student will identify his/her symptoms of allergic reaction (from mild to severe) and share information with school personnel. ☑ Student will actively participate in healthcare management and ECP at school. ❒ Student will understand medication administration and return demonstration (if indicated by parent & physician).

Kerry Burneyko, RN, BSN, CSN ▿ Green Hills School ▿ 69 Mackerley Road ▿ Greendell, NJ 07839 ▿ 973-300-3800 x 215 ▿ Fax 973-300-0617

ANAPHYLAXIS INDIVIDUALIZED HEALTHCARE PLAN (page 2)

			from home ***or*** parent has spoken with Maschio's dietitian re: safe menu selections. ☑ Distribute list of approved foods for classroom celebrations to all parents and teachers. Ensure Homeroom Parents allow only these products. ☑ Make any field trip and extracurricular activity modifications that are needed. ☑ Maintain epinephrine in secure, unlocked location. ☑ Encourage student to wear identification bracelet/necklace, to be obtained by parent. ☑ Document each episode of reaction & severity.	

Additional Notes: _____

_____

_____

_____

School Nurse Signature: _____ Date: _____

Annual IHP Review (for subsequent years):

Parent/Guardian Sig.:	Date:	*Parent/Guardian Sig.*:	Date:
Student Sig. (if appropriate):	Date:	*Student Sig. (if appropriate)*:	Date:
Nurse Sig.:	Date:	*Nurse Sig.*:	Date:
Parent/Guardian Sig.:	Date:	*Parent/Guardian Sig.*:	Date:
Student Sig. (if appropriate):	Date:	*Student Sig. (if appropriate)*:	Date:
Nurse Sig.:	Date:	*Nurse Sig.*:	Date:

Kerry Burneyko, RN, BSN, CSN ▿ Green Hills School ▿ 69 Mackerley Road ▿ Greendell, NJ 07839 ▿ 973-300-3800 x 215 ▿ Fax 973-300-0617

IMPORTANT PARENT AUTHORIZATIONS REGARDING SCHOOL FOOD

Student Name: _____ Grade: _____ DOB: _____

Cafeteria Food and Nut-Free Lunch Table:

- **No school or cafeteria staff can determine what cafeteria foods your child is permitted to eat; it remains your responsibility to review the ingredients of any item(s) that you want your child to buy. The safest option is for you to send a bagged lunch from your home.**
- Hot Lunch– The food served in the cafeteria is not certified nut or allergen-free. **HOWEVER, Maschio's (our cafeteria provider) now offers a Food Allergy Management Program that you can sign up for. More information on that program is linked here, or you can ask the school nurse for further details.**
- Packaged Food – If you wish to have your child purchase a pre-packaged snack (bag of pretzels, etc.) from the cafeteria, please come in to read the labels and determine what is/isn't appropriate for your child.
- Tables – Other students may bring food from home that contains nuts/other allergens. Therefore we have designated Nut-Free Tables in the cafeteria.

➤ Parent/Guardian: **I have reviewed the above information and acknowledge that I am responsible for determining what cafeteria foods my child is permitted to eat. I have checked below where my child will sit:**

☐ My child **does not** have to sit at the Nut-Free table. My child may sit at any cafeteria table.

☐ My child **has** to sit at the Nut-Free table with a friend until further notice. I will send nut-free lunches.

Parent/Guardian Signature: _____ Date: _____

Classroom Parties:

There are many party snacks given out during the year in the classroom. We try our best to keep them allergen-free, but it is beyond the school's ability to guarantee an allergen-free environment. You may send in a box of allergen-free treats for your child to eat on party/special occasion days, or you may sign the Food Allergy Waiver on the following page stating you are solely responsible to monitor what your child eats.

The list of approved Class Party Foods is posted on Greenhills.org, under Nursing Health Services (filed under Departments). These are the options we suggest to Green Hills parents and teachers. The majority of them are also approved by SnackSafely.com. Please review the ingredients of the items on the list. As of the time of printing, all items included are free of nuts, dairy, eggs, wheat/gluten, and sesame. **However, the school approved snack list is reviewed only once at the beginning of each year. Parents are responsible for staying aware of the most current ingredients for any given treat their child consumes.**

You must correspond directly with your child's Teacher and/or Class Parent to indicate which items, if any, you give permission for your child to eat. Also, if you wish, you are welcome to discuss attending all class celebrations serving food so that you can monitor your child's food intake.

➤ Parent/Guardian: **I have read and understand the above information regarding classroom parties. I will review the list of class party treats and correspond with my child's teacher and/or Class Parent about my preferences on class party days. I also give permission for the Class Parent to contact me via phone/email re: what will be served at class parties.**

Parent/Guardian Signature: _____ Date: _____

GREEN TOWNSHIP BOARD OF EDUCATION

Permission Form and Release re: Food Allergies

I/We grant permission for my child, _____, to consume food or drink items not brought in from our own home, including, but not limited to, cupcakes, cakes, cookies and other similar food items which may be purchased or brought in by my child or other students at school events such as birthday parties, holiday celebrations and field trips. I understand that these food items may contain allergens which could present a risk of allergic reaction or anaphylactic shock.

I further understand that after my execution of this waiver, school officials will not monitor any food or drink consumed or contacted by my child, and that I may not request school officials to selectively enforce this waiver with regard to allowable consumption of certain food items.

By signing below, I/We agree to voluntarily release, indemnify, defend and hold harmless the Green Township Board of Education, collectively and individually, as well as its agents, servants, employees and volunteers, from any and all claims which may be brought individually by my/our child or on our/their behalf now and forever, arising out of or connected with, either directly or indirectly, my child's distribution, ingestion or contact with such food items.

I may rescind this waiver, in its entirety, by notifying the Superintendent in writing of my intent to do so, which will become effective immediately upon the Superintendent's receipt of my written notification.

By signing this form, I certify that I am a parent/guardian of the above-named student, that I fully understand my/our rights and responsibilities under this Agreement and that I am legally capable of entering into this Release.

_____ _____

Date Signature of Parent/Guardian

_____ _____

Date Signature of Parent/Guardian