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| **Medical Management Plan** | **ALLERGY** |
| **SCHOOL YEAR**  | **2024-2025** |

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| Student Name: |  | Date of Birth: |  |
| **Physician’s Name:** |  | Phone #: |  |
| Address: |  | Fax #: |  |

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| **Allergy To:** |  |  | Asthma: | Yes |  | No |  |  |
|  \*Higher risk for severe reaction if student has asthma\* |
| **STEP 1:** | **TREATMENT** |  |  |  |  |  |
| **Symptoms:** |  |  | **\*\*Give Checked Medication\*\*** |
|  | \*To be determined by physician authorizing treatment\* |
| If a food allergen has been ingested, but no symptoms |  |  | Epinephrine |  | Antihistamine |
| MOUTH: | itching, tingling, or 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\*: | tightening of throat, hoarseness, hacking cough |  |  | Epinephrine |  | Antihistamine |
| LUNG: | shortness of breath, repetitive coughing, wheezing |  |  | Epinephrine |  | Antihistamine |
| HEART | thready pulse, low blood pressure, fainting, pale, blueness |  | Epinephrine |  | Antihistamine |
| Other: |  |  |  | Epinephrine |  | Antihistamine |
| If reaction is progressing (several of the above areas affected), give |  |  | Epinephrine |  | Antihistamine |
|  | \*potentially life-threatening. The severity of symptoms can quickly change\* |  |  |  |  |  |
| **Epinephrine:****DOSAGE** | **Rout: IM****(circle one)** | **EpiPen®****0.15 mg OR 0.30mg** | **Auvi-Q****0.15 mg OR 0.30 mg** | **Generic Epinephrine Auto Injector****0.15 mg OR 0.30 mg** |
|  **Antihistamine/Other:**  |  |
|  | **Medication/dose/route** |
| **STEP 2: EMERGENCY CALLS** |  |
| * **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.**
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| * **Call parent/guardian or emergency contact if unable to reach parent.**
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| *Nursing services are recommended for the care of this student during the school day.* |
| **Physicians Signature:** |  | **Date:** |  |

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| **Florida Statute 1002.20****Florida law states a student with life- threatening allergies may carry an epinephrine auto injector while at school and school- sponsored activities with approval from his/her parents and physician.** **The above named child may carry and self-administer his/her Epinephrine auto injector.**

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| **Parent/Guardian Signature: (Required)** |  | **Date:** |  |
|  |  |  |  |
| **Physician’s Signature: (Required)** |  | **Date:** |  |
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| **Continued Allergy Plan for (Student NAME)** |  |

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| **IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine during anaphylaxis.** |

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| Is your child compliant with their current treatment regime? | Yes |  | No |  |
| Does your child function independently with medication administration? | Yes |  | No |  |
| Are there any activity restrictions for your child? | Yes |  | No |  |
| If yes, please list: |  |  |  |  |  |

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| **PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information**  |
| I authorize my child’s school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child’s physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.As the parent or guardian of the student named above, I request that the principal or principal’s designee assist in the administration of medication/treatment prescribed for my child.I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel. |
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| **Parent/Guardian Signature** |  | **Print Name** |  | **Date** |

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| **Parent Contact Information** |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |