Medical Management Plan ALLERGY

SCHOOL YEAR 2024-2025

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

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.**
- **Call parent/guardian or emergency contact if unable to reach parent.**

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

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.

Parent/Guardian Signature: (Required) _____ **Date:** _____

Physician's Signature: (Required) _____ **Date:** _____

GRAYER, ISIAH

Continued Allergy Plan for (Student NAME) _____

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

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: _____

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.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

Parent Contact Information

Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____