

Medical Management Plan
SCHOOL YEAR 2019-2020

ALLERGY

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 metered dose inhaler.

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

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

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	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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: _____