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:** _____

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: _____