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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.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| * **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:** | | |  | | | | | |

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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.**   |  |  |  |  | | --- | --- | --- | --- | | **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. | | | | |
|  |  |  |  |  |
| **Parent/Guardian Signature** |  | **Print Name** |  | **Date** |

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