

**Medical Management Plan**  
**SCHOOL YEAR 2022-2023**

**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\*

|                     |                     |                          |                           |  |
|---------------------|---------------------|--------------------------|---------------------------|--|
| <b>Epinephrine:</b> | <b>Rout: IM</b>     | <b>EpiPen®</b>           | <b>Auvi-Q</b>             | <b>Generic Epinephrine Auto Injector</b> |
| <b>DOSAGE</b>       | <b>(circle one)</b> | <b>0.15 mg OR 0.30mg</b> | <b>0.15 mg OR 0.30 mg</b> | <b>0.15 mg OR 0.30 mg</b>                |

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.

|                                  |                   |             |
|----------------------------------|-------------------|-------------|
| <b>Parent/Guardian Signature</b> | <b>Print Name</b> | <b>Date</b> |
|----------------------------------|-------------------|-------------|

**Parent Contact Information**

|                        |             |
|------------------------|-------------|
| Parent/Guardian: _____ | Cell: _____ |
|                        | Work: _____ |
| Parent/Guardian: _____ | Cell: _____ |
|                        | Work: _____ |