

**Medical Management Plan**  
**SCHOOL YEAR 2024-2025**

**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 Epinephrine auto injector.

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"/>
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Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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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: \_\_\_\_\_