ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

ALLERGY MEDICAL MANAGEMENT PLAN
SCHOOL YEAR 2016-2017

Name: _____ Grade: _____ Date of Birth: _____

Teacher: _____ Room: _____

Plac

ALLERGY TO: _____ **Asthma ☐ Yes* ☐ No**

Higher risk for severe reaction if asthmatic

Allergy Healthcare Provider: _____ Phone: _____

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

DOSAGE

Epinephrine: IM (circle one) EpiPen® 0.30 mg EpiPen®Jr. 0.15 mg Auvi-Q 0.15 mg Auvi-Q 0.30 mg

Antihistamine/Other: give _____
medication / dose / route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parent/guardian or emergency contact if unable to reach parent.

Physician's Signature _____ Date _____

Physician's Printed Name/Stamp_____

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:_____

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

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

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 Date

Parent/Guardian/Emergency Contact Information:

_____ Ph: (C) _____ (W) _____ (H) _____
Parent/Guardian

_____ Ph: (C)_____ (W) _____ (H) _____
Parent/Guardian

_____ Ph: (C) _____ (W) _____(H) _____
Emergency Contact

_____ Ph: (C) _____ (W) _____ (H) _____
Emergency Contact