ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

ALLERGY MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

Name: _____ Grade: _____ Date of Birth: _____

Teacher: _____ Room: _____

Place ID Photo Here

ALLERGY TO: _____ **Asthma [ ] Yes* [ ] No**
Higher risk for severe reaction if asthmatic

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

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

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Allergy Healthcare Provider: _____ Phone: _____

Other 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: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Auvi-Q™ Twinject™

Antihistamine: give _____
medication / dose / route

Other: give _____
medication / dose / route

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

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 listed on page 1 if unable to reach parent.**
3. **Call physician. Contact information listed on page 1.**

Even if parent/guardian cannot be reached, do not hesitate to medicate or take child to medical facility.

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Doctor's Printed Name _____ Date _____

ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ Date of Birth:_____

School: _____Grade:_____Teacher/Homeroom: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered.
A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment:_Benadryl/Allergy Relief___Amount (Dosage):_____

Time to be given: _____Date to start: _____Date to end:_____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., may carry epi-pen/Glucagon on person)**: _____**

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____FAX: _____

Physician's signature: (required for all medications)_____

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 ***Work/Home/Cell Phone*** ***Date***

ASTHMATIC OR ALLERGIC STUDENTS: POSSESSION OF INHALERS OR EPIPENS — Florida Statute 1002.20

*Florida law states an asthmatic student or allergic student may carry a prescribed metered dose inhaler or epipen on his/her person while in school with approval from his/her parents **and** physician.*
The above named child may carry and self-administer his/her metered dose inhaler or epipen

Parent/Guardian Signature:_____ Date:_____

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

ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ Date of Birth:_____

School: _____ Grade: _____ Teacher/Homeroom: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered.
A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment:_EpiPen/Auvi-Q_____Amount (Dosage):_____

Time to be given: _____Date to start: _____Date to end:_____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., may carry epi-pen/Glucagon on person)**: _____**

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____FAX: _____

Physician's signature: (required for all medications)_____

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 ***Work/Home/Cell Phone*** ***Date***

ASTHMATIC OR ALLERGIC STUDENTS: POSSESSION OF INHALERS OR EPIPENS — Florida Statute 1002.20

*Florida law states an asthmatic student or allergic student may carry a prescribed metered dose inhaler or epipen on his/her person while in school with approval from his/her parents **and** physician.*
The above named child may carry and self-administer his/her metered dose inhaler or epipen

Parent/Guardian Signature:_____ Date:_____

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