# Medical Management Plan ALLERGY

## SCHOOL YEAR 2025-2026

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*

| 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:** _____

**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:** _____

**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 | | 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: _____

## 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: _____