Pasco County Schools

Anaphylaxis Medical Management Plan

Student Name:	**D.O.B:**	**School Year:**
Allergy to:	Asthma: _____Yes ***higher risk for severe reaction*** _____ No	
Other health problems besides anaphylaxis	**Other medications:**	

Symptoms of Anaphylaxis

Mouth	Itching, swelling of lips and/or tongue
Throat*	Itching, tightness/closure, hoarseness
Skin	Itching, hives, redness, swelling
GI:	Vomiting, diarrhea, cramps
Lung*	Shortness of breath, cough, wheeze
Heart*	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
*Some symptoms can be life threatening. **ACT FAST!**

Emergency Action Steps

DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

_____ Epi-pen Jr. (0.15 mg.) _____ Epi-pen (0.3 mg.)
_____ Adrenaclick (0.15 mg.) _____ Adrenaclick (0.3 mg.)
_____ Auvi-Q (0.15 mg.) _____ Auvi-Q (0.3 mg.)
Epinephrine injection, USP Auto-injector – authorized generic
_____ (0.15 mg.) _____ (0.3 mg.)

Other (specify): _____

ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!

2. Call 911 immediately! Call emergency contacts next.
3. Emergency contact #1: home_____work_____cell_____

Emergency contact #2: home_____work_____cell_____

Parent has provided emergency medication to school: ☐ YES ☐ NO

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.

Print, type, or stamp Physician's Name & Information: _____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Adapted from American Academy of Allergy, Asthma & Immunology www.aaaai.org.

Revised 9/2017

AUTHORIZATION TO CARRY AND SELF ADMINISTER ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

Student Name (print) _____ Parent / Guardian Name (print) _____

Student Number _____ Grade _____ Name of School _____

Name of Medication _____

In order for your child to carry and administer his/her own inhaler/epi-pen/or pancreatic enzyme supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the Medical Management Plan, which further sets forth the parental authorization and licensed prescriber's acknowledgement concerning the self-administration of medication.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me, in the student's Medical Management Plan, without assistance. This student should be allowed to carry and use the equipment/medication(s) listed above.

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's inhaler/epi-pen/or PES. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use or misuse of such medication pursuant to s. 1002.20(3)(h),(i) and/or (k).

Date _____ Parent / Guardian Signature _____

Date _____ Student Signature _____

Pasco County Schools
General Guidelines for Administration of Medication at School

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools' trained personnel to administer the following medication to:
(Name of school)

_____
(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.
(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

_____

Possible reactions / side effects: _____

_____

I hereby authorize designated Pasco County Schools' staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed.

_____ Date: _____
(Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*

FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

DO NOT WRITE IN THIS AREA
6686081904

School Year: _____ *(Año escolar)*

PART A **Parent / Guardian: Complete Items 1 - 16** *(Padre/madre/tutor: complete la información en los espacios 1 al 16)*

1) Student ID# *(Numero de estudiante)* | 2) Student's Last Name *(Apellido)* | 3) Student's First Name *(Nombre del estudiante)* | 4) Date of Birth *(Fecha de nacimiento)*

5) School *(Escuela)* | 6) Grade *(Grado)* | 7) Student assigned in: ☐ PreK/EHS ☐ PreK VE ☐ Charter ☐ K-12

Parent/Guardian Name & Contact Information *(Nombre & Información del contacto)*

8) Name *(Nombre)* | 9) Phone Number *(Teléfono)* | 10) Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

11) E-mail Address (We will use this to send acknowledgement and details of your child's menú plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

12) **Meals Eaten at School**
(Los alimentos que su niño(a) consumirá en la escuela)
☐ Breakfast *(Desayuno)* ☐ Snack *(Meriendao)*
☐ Lunch *(Almuerzo)* ☐ None *(Nada)*

13) **Allowable Parent Request:** *(Solicitud de los padres)*
☐ Lactose Intolerance *(intolerancia a lactosa)* *(Lactaid Milk needed)* *(necesita leche Lactaid)*
If lactose intolerant, mark if can eat (marque si puede comer) ☐ Cheese *(queso)* ☐ Yogurt *(yogur)*
☐ Cultural/Religious Preference *(preferencias culturales/religiosas)*
☐ Pork *(carne de cerdo)* ☐ Beef *(carne de res)* ☐ Other *(otro)* _____
☐ Other Condition (Must be diagnosed by physician using Part B) *(Otro condición- debe ser diagnosticado por un médico en la parte B)*

14) **Does the student have an identified disability (IEP or 504 Plan)?**
¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ Yes *(Si)* ☐ No

15) **I consent to the exchange of information between the physician and school, as needed.**
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)
Parent / Guardian Signature (required for processing) *(Firma del padre/madre/tutor - requerido para ser procesado)* X | **Date** *(Fecha)*

16) **Parent/Guardian: It is REQUIRED that this completed form is returned to the cafeteria manager. All further changes to the child's diet must be made by a physician on a new form with the exception of lactose intolerance or cultural preference. The manager will add the alert to the cashier system & return the form to the District FNS Office for consideration.**
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. El gerente de la cafetería añadirá un alerta en el sistema de cajeros y devolverá la forma a las oficinas de Alimentos y Nutrición del Distrito)
*Information regarding major allergens and nutrient/carbohydrate information are available for review at http://schools.mealviewer.com/district/pascocounty
(Ver información sobre alergenos y nutrientes/carbohidratos en http://schools.mealviewer.com/district/pascocounty)

PART B **COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 20** *(17 al 20 - Esta sección para ser completada por el médico solamente)*

17) **Student Diagnosis or Condition** ☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy ☐ Other (Specify) _____
**** Students with life threatening food allergies must have an emergency action plan in place at school.***

18) **Please check all food(s) to omit from child's diet during the school only (not to be used as a medical history):**

DAIRY
- ☐ Fluid Milk. Substitute with ☐ lactose-free milk ☐ soy milk ☐ water
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Ice Cream
- ☐ Yogurt
- ☐ Baked goods with any dairy listed as an ingredient

EGG
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ Baked goods with any egg listed as an ingredient

WHEAT / GLUTEN
- ☐ Recipes with any wheat listed as an ingredient

FISH OR SHELLFISH
- ☐ Fish
- ☐ Shellfish

PEANUTS OR TREE NUTS
- ☐ Peanuts
- ☐ Tree Nuts

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn products listed as an ingredient

SOY
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Recipes with any soy listed as an ingredient

OTHER
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

_____
_____

19) **Does the student have a disability, medical condition, or severe food allergy warranting a special diet?** ☐ Yes If "YES", specify disability below
A disability is defined as a physical or mental impairment which substantially limits one or more major life activities. ☐ No **If "NO", A SPECIAL DIET IS NOT WARRANTED.**

Disability (specify) _____ Describe major life activities affected _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

20) **LICENSED PHYSICIAN'S INFORMATION** ***Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.***

Medical Authority Signature X | Date | Medical Office Stamp (Required for processing)

Medical Authority Printed Name