 Pasco County Schools

Anaphylaxis Medical Management Plan

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| **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!*   1. Call 911 immediately! Call emergency contacts next. 2. Emergency contact #1: home work cell   Emergency contact #2: home work cell  **Parent has provided emergency medication to school: ☐ YES ☐ NO**  ***Print, type, or stamp Physician’s Name & Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  Address: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: Fax: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I hereby authorize the above-named physician and Pasco County School’s 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. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent’s Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district’s resources identifying my rights (including the notices located at**  [**https://www.pasco.k12.fl.us/ssps/page/parent\_notices**](https://www.pasco.k12.fl.us/ssps/page/parent_notices)**, and pursuant the Parent’s Bill of Rights, Chap.1014, Fl. Stat.),**  **and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.** | | |

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

*Revised 5/2022*