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.)

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 □

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: ____________

Revised 7/2016

Parent/Guardian Authorization for Medication Administration 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'
(Name of school)
trained personnel to administer the following medication to:

______________________ ______________ __________ __________
(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*