# Maclay School

## Individualized Student Allergy Action and Care Plan for 2024-2025 School Year

Student's Name: ____________________________________________ DOB: _______________________

Grade Level: ______________ Teacher/Homeroom: ___________________________________________

**ALLERGY TO**: ______________________________________________________________

Asthma Diagnosis (circle one)? Yes* or No *Higher risk for severe reactions

**STEP 1: TREATMENT – This section to be completed by PHYSICIAN authorizing treatment**

| **Symptoms:** | **Give Checked Medications:** | |
|---|---|---|
| ▪ If exposed to allergen, 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 |
| ▪ Lungs †: 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 |

The severity of symptoms can quickly change. † Potentially life-threatening

## MEDICATION AND DOSAGE:

**Epinephrine:** Inject intramuscularly (circle one or list) EpiPen EpiPen Jr. Other: ________

**Antihistamine:** Give by mouth ____________________________________________________

**Other:** Give (medication/dose/route) ______________________________________________

**STEP 2: EMERGENCY CALLS**

1. **Call 911 – State that an allergic reaction has been treated and additional epinephrine may be needed. DO NOT HESITATE TO MEDICATE OR CALL 911 IF PARENT/GUARDIAN CANNOT BE REACHED.**
2. Dr. __________________________________________ at _________________________________
3. Emergency Contacts: Name/Relationship Phone Number
   1) _____________________________________ primary number _________________________
   2) _____________________________________ primary number _________________________
   3) _____________________________________ primary number _________________________

**LOCATION OF INTRAMUSCULAR EPINEPHRINE:** ______________________________________________

**Parent/Guardian Signature** ________________________________________ **Date** _________________

**Physician's Signature** _____________________________________________ **Date** _________________

Reviewed by Maclay School RN Signature: ____________________________________________Date ______________________(rev 12/2022)

# AUTHORIZATION TO CARRY AND SELF ADMINISTER

Maclay School

STUDENT NAME: ____________________________________ DATE OF BIRTH: ___________________________

GRADE: _________________________ HOMEROOM: _______________________________________________

PARENT/GUARDIAN: _______________________________ PARENT/GUARDIAN PHONE: _________________

## I. PARENT/GUARDIAN PERMISSION:

I hereby request and give permission for my child to be allowed to carry and/or self-administer the medication marked below by physician initials per Florida Statute while in school and away from school for school-related activities. Administration will be in compliance with written directions from my child's physician per the written prescription. I will notify the school immediately if the health status of my child changes, we change physicians, we change home, work, or emergency telephone numbers, or there is a change or cancellation of the order. I understand it is my responsibility to ensure that my child has the proper medication, that it is within the expiration date for his/her use, and that the delivery system is functioning properly. I understand that no other medications other than those listed below are allowed to be carried by my student. I acknowledge that the school nurse is authorized to provide training to any school personnel as required, and that the school nurse has the authority to revoke the self-administration privilege for any student the nurse may assess as unsafe or ineffective in his/her professional judgment. If my student can self-administer, it is strongly encouraged that a back-up supply of medication is provided to the school clinic. I understand that if my student cannot self-administer their own medication, I must provide a back-up supply for the school clinic. I hereby agree to indemnify and hold Maclay School and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them rising from harm to any persons caused by my child's actions with regards to self-carried medication.

PARENT/GUARDIAN SIGNATURE: _________________________________ DATE: ____________________

## II. PHYSICIAN STATEMENT:

The above named student may carry and/or self-administer the following medication as outlined below *(please mark all boxes that are applicable and initial to the right of all marked boxes)*:

**Metered Dose Inhaler (MDI)** ☐ Student may carry ☐ Student may self-administer *Initials*: _____

**Epinephrine (autoinjector)** ☐ Student may carry ☐ Student may self-administer *Initials*: _____

**NOTE: If Epinephrine is used, 9-1-1 MUST be activated!**

**Pancreatic Enzyme Supplement** ☐ Student may carry ☐ Student may self-administer *Initials*: _____

PHYSICIAN SIGNATURE: ________________________________________ DATE: _________________________

PHYSICIAN NAME (please print): _______________________________________ TELEPHONE: ______________

## III. REGISTERED NURSE STATEMENT:

I acknowledge that the student named above is authorized to carry and/or self-administer the indicated medication above, and it is my professional judgement that this student can safely and effectively carry and/or self-administer this medication.

REGISTERED NURSE SIGNATURE: _______________________________________ DATE: ___________________

REGISTERED NURSE NAME (please print): _________________________________

**A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR**