

STUDENT ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN (EPIPENS)

MUST BE COMPLETED AND SIGNED BY A PHYSICIAN AND SIGNED BY PARENT -2025-2026 School Year



Student's Name: _____ DOB: _____

Age: _____ Weight: _____ lbs Grade Level/Homeroom Teacher: _____

Allergic to: _____

Student has asthma	☐ YES ☐ NO (IF YES, HIGHER CHANCE FOR A SEVERE REACTION)
Student has a history of anaphylactic reaction(s)	☐ YES ☐ NO (IF YES, PLEASE LIST DATE(S): _____)
Student may self-carry EpiPen	☐ YES ☐ NO
Student may self-administer EpiPen	☐ YES ☐ NO

Extremely reactive to the following allergens: _____

☐ If checked, give EPIPEN immediately if the allergy was **LIKELY** eaten and student is having **ANY SEVERE** symptoms.

☐ If checked, give EPIPEN immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

☐ If checked, give _____.

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:				MILD SYMPTOMS:			
LUNGS	THROAT	HEART	MOUTH	NOSE	MOUTH	SKIN	GUT
-Shortness of breath -Wheezing -Persistent coughing	-Tight throat -Hoarse voice -Trouble swallowing -Trouble breathing	-Pale or bluish skin -Faintness -Dizziness -Rapid pulse	-Significant swelling of the tongue or lips	-Itchy or runny nose -Sneezing	-Itchy mouth	-A few hives -Mild itch	-Mild nausea or discomfort
				FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:			
SKIN	GUT	OTHER	OR A COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS	1. Antihistamines may be given, if ordered by a healthcare provider (see below under MEDICATIONS). 2. Stay with the person; alert emergency contacts. 3. Watch closely for changes. If symptoms worsen, give epinephrine and call 911.			
-Many hives over the body -Widespread redness/flushing -Facial swelling	-Vomiting -Diarrhea -Stomach cramps	-Feeling of impending doom, anxiety, confusion		FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.			
↓ ↓ ↓ 1. ADMINISTER EPINEPHRINE IMMEDIATELY. 2. CALL 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive. - Consider giving additional medications following epinephrine: - Antihistamine (such as Benadryl) and as directed on this Action Plan - Inhaler (bronchodilator) if wheezing and as directed on this Action Plan - Lay the person flat, raise legs, and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. - If symptoms do not improve, or symptoms return, another dose of epinephrine can be given about 5 mins after the last dose. - Alert parent or guardian as soon as possible. - Student must be transported to ER by EMS even if symptoms resolve.				MEDICATIONS AND DOSAGE: Epinephrine: inject intramuscularly (circle one or list) – EpiPen EpiPen Jr. Other: _____ Antihistamine (brand or generic): _____ Antihistamine Dose: _____ Other (e.g., inhaler): _____ ☐ Student may self-carry ☐ Student may self-administer			
				EMERGENCY CONTACTS – CALL 911 PARENT/GUARDIAN: _____ PRIMARY #: _____ PARENT/GUARDIAN: _____ PRIMARY #: _____			

Physician's Printed Name: _____ Date: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION TO CARRY AND SELF ADMINISTER

MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN AND PHYSICIAN ONLY IF YOUR CHILD IS AT AN APPROPRIATE AGE TO

SELF CARRY/SELF ADMINISTER (OTHERWISE, THIS FORM IS NOT REQUIRED)

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

Permission Form for Administration of Medications at School

MUST BE FILLED OUT AND SIGNED BY A PARENT; PLEASE INCLUDE PERMISSION FOR EPIPEN AND ANTIHISTAMINE OF CHOICE (EX: BENADRYL)

I hereby certify that it is necessary for Maclay Student

Student's Name: _____ Date of Birth: _____ Grade Level: _____

Known ALLERGIES: _____

To be given during the school day, including when they are away from school property on official school business.

Medication (#1): _____ **Reason for Medication:** _____

Dosage: _____ Route: _____ Time(s) of administration: _____

Beginning date: _____ Ending date: _____ Amount of liquid or pills: _____

Special Instructions: _____

Medication (#2): _____ **Reason for Medication:** _____

Dosage: _____ Route: _____ Time(s) of administration: _____

Beginning date: _____ Ending date: _____ Amount of liquid or pills: _____

Special Instructions: _____

Medication (#3): _____ **Reason for Medication:** _____

Dosage: _____ Route: _____ Time(s) of administration: _____

Beginning date: _____ Ending date: _____ Amount of liquid or pills: _____

Special Instructions: _____

Emergency Contacts:

Name: _____ Number: _____

Doctor's Name: _____ Number: _____

Prescription and non-prescription medication shall come in original container. Prescription labels will be the current, official pharmacy label will designate the patient's name, dosage and time of administration and prescribing doctor. Changes in the medication times can be made by written prescription from physician. This permission form is valid for current school year only. I hereby consent to protected health information being used and disclosed to carry out treatment or healthcare operations of my child. I understand that Maclay School may need to give and receive protected provider listed above, and I hereby authorize the exchange of information as needed to carry out the treatment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services at Maclay School for the limited purposes of meeting my child's health and education needs.

I hereby authorize Maclay School and their officers, employees, agents, to assist my child with medications administration and/or to supervise self-administration of medications. I acknowledge and agree that non-health professionals, trained in medication administration may assist my child with medication administration. I hereby release, indemnify, and hold harmless Maclay School and any of their officers, employees, contractor, and agents against all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also 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.

It is understood by the undersigned that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances. By signing below, the Parent/guardian represents and warrants that the medication provided to Maclay School is as described above; furthermore, the parent/guardian agrees to hold Maclay school harmless from any claims and/or damages arising out of or related to the provision of the medication provided by the parent/guardian as described above. Parents are requested to pick up any leftover medication within one week after the ending date. Medication left after that time will be discarded.

I am the parent/guardian of the child named above. I give permission for the information on this form to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services for the limited purposes of meeting my child's health and educational needs.

Parent /Guardian Signature: _____ **Date:** _____

Parent/Guardian Name & Relationship (Print): _____