Place Child's Picture Here

LEON COUNTY SCHOOLS

Individualized Student Allergy Action and Care Plan for _____ School Year

Student Name: _____ DOB: _____

School: _____ Grade: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthma Diagnosis? ☐ Yes* ☐ No *Higher risk for severe reaction

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

Symptoms:		Give Checked Medication:	
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
Lung †	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 _____
medication/dose

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. EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911!**
2. Dr. _____ at _____
3. Emergency contacts: Name/Relationship Phone Numbers

1. _____ h _____ w _____ c _____

2. _____ h _____ w _____ c _____

3. _____ h _____ w _____ c _____

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

LOCATION OF INJECTABLE EPINEPHRINE: _____

Reviewed By LCHD School RN Signature: _____ Date: _____

LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT
(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____(first/last name), _____(date of birth), to be given the medication or treatment listed below during the school day, including when she/he is away from school property on official school business. I hereby authorize the School Board of Leon Count, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors, and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication (s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

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

Emergency telephone numbers:

Parent/Guardian: _____ H: _____ C: _____

Parent/Guardian: _____ H: _____ C: _____

Doctor's name: _____ Doctor's Phone Number: _____

Prescription and over-the-counter medications/treatments shall come in the original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered for **five calendar days** without a signed licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy.

Parents are responsible for safe delivery of medication to the school (students may NOT transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC, and any of their officers, employees, contractors, and agents from any and 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 LCSB, DOHLC and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____

Date Parent/Guardian Signature

LEON COUNTY SCHOOLS
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_____ _____

Date Parent/Guardian Signature

Leon County Schools

AUTHORIZATION TO CARRY MEDICATION(S) PERMITTED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify).

Medication and/or Supplies: _____

_____

Dosage/Instructions: _____

_____

Diagnosis: _____

Physician Signature	Physician Name	Phone Number	Date
_____	_____	_____	_____

I have read and understand the waiver of liability statements on the Authorization for Medication (Page 1) and feel that my child is capable of self-management and administration of the above medication/supplies.

Parent Signature	Parent Name	Phone Number	Date
_____	_____	_____	_____

For staff use only

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

FDOH RN Signature	FDOH RN Name	Phone Number	Date
_____	_____	_____	_____

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year _____

Student's Name: _____

DOB: _____

School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

____ [X] Leon County School District

____ [ ] Tallahassee Memorial Hospital Diabetes Center

____ [ ] Children's Medical Services

(Name of case manager: _____)

____ [X] Florida Department of Health in Leon County (Health Department)

____ [ ] Tallahassee Pediatric Foundation

____ [ ] Primary Physician _____

(Please fill in Physician name)

____ [ ] Specialist Physician _____

(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____ _____

Signature Date