

## 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:

- If exposed to allergen, but no symptoms:
- Mouth- itching, tingling, or swelling of lips, tongue, mouth
- Skin- Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat \* Tightening of throat, hoarseness, hacking cough
- Lung\* Shortness of breath, repetitive-coughing, wheezing
- Heart\* Thready pulse, low blood pressure, fainting, pale, blueness
- Other\* \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change.

\* Potentially life threatening

### Give Checked Medication

___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine

### 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. Physician Name \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

#### Name/Relationship

#### Phone Numbers

1. _____	H _____	W _____	C _____
2. _____	H _____	W _____	C _____
3. _____	H _____	W _____	C _____

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician'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 County, 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
RN Signature

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Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Amount of liquid or count of pills: \_\_\_\_\_

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
RN 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)**

\_\_\_\_ ☒ Leon County School District

\_\_\_\_ ☐ Tallahassee Memorial Hospital Diabetes Center

\_\_\_\_ ☐ Children's Medical Services

(Name of case manager: \_\_\_\_\_)

\_\_\_\_ ☒ Florida Department of Health in Leon County

\_\_\_\_ ☐ 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.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date