CLAY COUNTY SCHOOL DISTRICT
FLORIDA DEPARTMENT OF HEALTH - CLAY COUNTY
SCHOOL HEALTH SERVICES
2016-2017

ALLERGY MEDICAL MANAGEMENT PLAN

(Must be filled out completely by Physician/Healthcare Provider)

OPJH Clinic Fax
904-278-2009

Student Name: ______________________________ DOB: ______________

Parent / Guardian: ______________________________ Phone: ______________

Physician / Provider: ______________________________ Phone: ______________

SEVERE ALLERGY TO: ____

DIETARY MODIFICATIONS/FOOD ALLERGIES: ☐Yes (**If yes, please see reverse side**) ☐No

ASTHMA: ☐ Yes (***higher risk for a severe reaction***) ☐ No

SYMPTOMS OF ANAPHYLAXIS

Mouth: Itching, swelling of lips and/or tongue
Skin: Hives, itching, redness, and/or swelling
Lung: Shortness of breath, coughing, wheezing
Throat: Itching, tightness/closure, hoarseness
Gut: Vomiting, diarrhea, cramps
Heart: Weak pulse, dizziness, fainting

***Only a few symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life-threatening.**

EMERGENCY MEDICATIONS

***Medications must go with student if he/she is off school grounds (i.e. band or field trips, sporting events, etc.)**

☐ **Epinephrine**

- Name of Medication: ______________________________
- Directions for use: ______________________________
- Location of epinephrine: ☐ School Nurse in Health Room ☐Carried by Student ☐ Kept with Teacher/Staff
- Student may self-administer: ☐Yes ☐No

☐ **Rescue Inhaler**

- Name of Medication: ______________________________
- Directions for use: ______________________________
- Location of Inhaler: ☐ School Nurse in Health Room ☐Carried by Student ☐ Kept with Teacher/Staff
- Student may self-administer: ☐Yes ☐No

☐ **Antihistamine** **(May only be carried by a student who carries Epinephrine)**

- Name of Medication: ______________________________
- Directions for use: ______________________________
- Location of antihistamine: ☐ School Nurse in Health Room ☐Carried by Student ☐ Kept with Teacher/Staff
- Student may self-administer: ☐Yes ☐No

MANAGEMENT OF ANAPHYLAXIS

1. **INJECT EPINEPHRINE IMMEDIATELY** (Note time when administered.)
2. Call 911
3. Monitor student
4. Give additional medications as ordered **

**Antihistamines & inhalers (bronchodilators) are not to be depended upon to treat a severe reaction (anaphylaxis). Use epinephrine first. If symptoms persist, a second dose of epinephrine may be given 5 minutes or more after initial dose (if available).

______________________________ ______________
Physician/Provider Signature **(Required)** **Date**

______________________________ ______________
School Nurse Signature **Date**

OFFICE STAMP

Revised 4/2016

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Student Name: ______________________________________ DOB: ___________________________

Parent Name: ____ Phone: ____________________

1. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/or accommodation. **A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.**

☐ Participant has a food allergy, not considered a disability. Food preferences are not an appropriate use of this form. Please note the food to be omitted below so the participant's meal account can be noted. **A medical authority's signature is not needed and a parent/guardian may complete this form.**

2. The participant's disability or medical condition requiring a special meal or accommodation:

3. If participant has a disability, provide a brief description of his/her major life activity affected by the disability (e.g., Allergy to peanuts causes life-threatening reaction):

4. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

5. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):

A. Foods To Be Omitted	B. Suggested Substitutions
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

6. Signature of Recognized Medical Authority*	7. Printed Name	8. Telephone Number	9. Date
10. Signature of Parent or Guardian	**11. Printed Name**	**12. Telephone Number**	**13. Date**

***For this purpose, a recognized medical authority is a licensed physician, physician assistant, or nurse practitioner.**

Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.