School District of Manatee County
School Health Services
Allergy Physician Orders and Action Plan

Place Student's Picture Here

Name of Student: _____ D.O.B ____/____/____

Allergy to: _____

Asthma: ☐ Yes (higher risk for severe reaction) ☐ No

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive, swelling (tongue and/or lips)
SKIN:	Many hives over body

Or Combination of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/ bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent; notify clinic
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

Changes to the above protocol: _____

_____

Medication / Doses

☐ If checked, give epinephrine immediately if allergen was eaten, even if no symptoms are noted.

Epinephrine (brand/dose) _____

Antihistamine (brand/dose) _____

Other (e.g.) inhaler-bronchodilator if asthmatic) _____

Student authorized to carry and use Epi-pen / asthma inhalation and self-administer ☐ Yes ☐ No

Physician's signature: _____ Date: _____ Phone:_____

Physician's Name (Print) _____

Physician's Address: _____

PARENT SECTION:

I hereby grant permission to the principal (or his/her designee) of my child's school to administer the above prescribed medication to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand the law provides 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 under the same or similar circumstances. I understand the school will not be responsible for monitoring a student's self medication.

Name: _____ Relationship: _____

Cell Phone # _____ Home Phone # _____ Business Phone # _____

Signature: Parent/Legal Guardian _____ Date: _____