Pasco County Schools

Anaphylaxis Medical Management Plan

Student Name:	D.O.B:	School Year:
Allergy to:	Asthma: _____Yes ***higher risk for severe reaction*** _____ No	
Other health problems besides anaphylaxis	Other medications:	

Symptoms of Anaphylaxis

Mouth	Itching, swelling of lips and/or tongue
Throat*	Itching, tightness/closure, hoarseness
Skin	Itching, hives, redness, swelling
GI:	Vomiting, diarrhea, cramps
Lung*	Shortness of breath, cough, wheeze
Heart*	Weak pulse, dizziness, passing out

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

Emergency Action Steps

DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

_____ Epi-pen Jr. (0.15 mg.) _____ Epi-pen (0.3 mg.)
_____ Adrenaclick (0.15 mg.) _____ Adrenaclick (0.3 mg.)
_____ Auvi-Q (0.15 mg.) _____ Auvi-Q (0.3 mg.)

Epinephrine injection, USP Auto-injector – authorized generic
_____ (0.15 mg.) _____ (0.3 mg.)

Other (specify): _____

ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!

2. Call 911 immediately! Call emergency contacts next.
3. Emergency contact #1: home_____work_____cell_____

   Emergency contact #2: home_____work_____cell_____

Parent has provided emergency medication to school: ☐ YES ☐ NO

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.

Print, type, or stamp Physician's Name & Information: _____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Adapted from American Academy of Allergy, Asthma & Immunology www.aaaai.org.

Revised 9/2017