ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

ALLERGY

School Year: 2025-2026

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

Allergy To: _____ Asthma: Yes ☐ No ☐

Higher risk for severe reaction if student has asthma

STEP 1: TREATMENT

Symptoms:

****Give Checked Medication****

To be determined by physician authorizing treatment

If a food allergen has been ingested, 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

potentially life-threatening. The severity of symptoms can quickly change

Epinephrine: DOSAGE	Rout: IM (circle one)	EpiPen® 0.15 mg OR 0.30mg	Auvi-Q 0.15 mg OR 0.30 mg	Generic Epinephrine Auto Injector 0.15 mg OR 0.30 mg

Antihistamine/Other: _____

Medication/dose/route

STEP 2: EMERGENCY CALLS

- **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.**
- **Call parent/guardian or emergency contact if unable to reach parent.**

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

Florida Statute 1002.20
Florida law states a student with life- threatening allergies may carry an epinephrine auto injector while at school and school- sponsored activities with approval from his/her parents and physician.
The above named child may carry and self-administer his/her Epinephrine auto injector.

Parent/Guardian Signature: (Required) _____ **Date:** _____

Physician's Signature: (Required) _____ **Date:** _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

ASTHMA

SCHOOL YEAR: 2025-2026

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Identify the things that start an asthma episode (check all that apply to the student)

- ☐ Exercise
- ☐ Chalk Dust
- ☐ Animals
- ☐ Molds
- ☐ Strong odors of fumes
- ☐ Change in temperature
- ☐ Pollens
- ☐ Other _____
- ☐ Respiratory infections
- ☐ Carpets in the room
- ☐ Food

Daily Medication Plan

Name of Medication	Amount/Dose	When to use
1.		
2.		
3.		

EMERGENCY ACTION is necessary when the student has symptoms such as: _____

***Steps to take during an asthma episode*: Give emergency medications listed below. Seek Emergency Medical Care if the student has any of the following: No improvement 15-20 minutes after initial treatment with medication, and a relative cannot be reached. Continued difficulty breathing. Trouble walking or talking. Stops playing and cannot start activity again. Lips or fingernails are gray or blue.**

Emergency Asthma Medications

Name	Amount/Dose	When to use
1.		
2.		
3.		

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

ASTHMATIC STUDENTS: POSSESSION OF INHALERS—Florida Statute 1002.20

Florida law states an asthmatic student may carry a prescribed metered dose inhaler on his/her person while in school with approval from his/her parents and physician.

The above named child may carry and self-administer his/her metered dose inhaler.

Parent/Guardian Signature: (Required) _____ **Date:** _____

Physician's Signature: (Required) _____ **Date:** _____

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