School District of Manatee County
School Health Services
Food Allergy/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 ingestion:

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 EPINEPRINE
4. Begin monitoring

I agree with the above protocol, except for the following orders:_____

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 inhaler and self-administer: ☐ Yes ☐ No

Physician Orders for Food Allergies:

Food(s) to be Omitted	Food(s) to be Substituted (if needed)

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 # _____

Review/Revised: 7/29/13