ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan ASTHMA

SCHOOL YEAR: _____

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:** _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Continued Asthma Plan for (Student NAME) _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

SEIZURE DISORDER

SCHOOL YEAR: _____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Type of seizures: _____

Please list all medications (HOME & SCHOOL): _____

_____

Are medications needed **during school hours?** ☐ Yes ☐ No

If yes, please list:

Name of medication	Prescribed Dose/Route	When to use

If Diastat or Midazolam is ordered, it should be given: ☐ At onset of seizure ☐ Minutes into seizure after ☐ Seizures in a row

Is VNS used? (if yes please instruct) ☐ Yes ☐ No _____

Are there activity limits? (if yes please describe) ☐ Yes ☐ No _____

Is protective equipment required? (if yes please describe) ☐ Yes ☐ No _____

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

Physicians Signature: _____ **Date:** _____

For Parent to Complete:

1. When was the last seizure? _____
2. At what age did the seizure activity begin? _____
3. Describe the seizure? _____

   _____
4. How often do seizures occur? _____
5. How long do the seizures normally last? _____
6. Has the seizure ever lasted longer than 5 minutes? ☐ Yes ☐ No

   If yes, how was it handled? _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Continued Seizure Plan for (Student NAME) _____

7. Does your child lose bowel or bladder control during a seizure? Yes ☐ No ☐
8. Has your child ever turned blue or stopped breathing during a seizure? Yes ☐ No ☐
   If yes, how was it handled?
9. Has your child ever required hospitalization due to a seizure Yes ☐ No ☐
   If yes, please explain:
10. Is there anything that seems to trigger a seizure? Yes ☐ No ☐
    If yes, please list:
11. Does your child experience an aura before a seizure? Yes ☐ No ☐
    If yes, please explain:

Other considerations that will assist the school in providing care for your child: _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

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I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	Print Name	Date

Parent/Guardian _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan — ALLERGY

School Year:_____

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

Continued Allergy Plan for (Student NAME) _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine during anaphylaxis.

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.
As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.
I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

Parent/Guardina Contact Information

Parent/Guardian: _____ Cell: _____
Work: _____

Parent/Guardian: _____ Cell: _____
Work: _____

ST. JOHNS COUNTY SCHOOL DISTRICT - HEALTH SERVICES

Medical Management Plan BLEEDING DISORDERS

SCHOOL YEAR: _____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Brief Description of bleeding disorder: _____

Medications: (Please list and note that IV medications are not given by school personnel.)

Restrictions: (Please list restrictions including physical education activities, a doctor's signature is required)

First Aid Treatment for Bleeding:

- Apply ice to the site
- Call 911
- Contact Parent/Guardian

Other: _____

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

Physicians Signature: _____ **Date:** _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

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Parent/Guardian Signature	**Print Name**	**Date**

Is your child compliant with their current treatment regime? Yes ☐ No ☐

Does your child function independently with medication administration? Yes ☐ No ☐

Are there any activity restrictions for your child? Yes ☐ No ☐

If yes, please list: _____

Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

CARDIAC

School Year: _____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Brief description of condition: _____

_____

Current Medications: _____

Name: _____ Dosage/Rout: _____ School ☐ Home ☐

Name: _____ Dosage/Rout _____ School ☐ Home ☐

Special Equipment: _____ School ☐ Home ☐

Symptoms child may demonstrate: Tires easily ☐ SOB ☐ Pain ☐ Other: _____

Vital Sign Parameters: B/P _____ Pulse _____ Respirations _____

Limitations: ☐ Cleared without limitations including all physical activities and recess.

☐ **Not Cleared** for (please be specific) _____

_____

If student complains of chest pain, shortness of breath and/or has vital signs outside acceptable parameters, school personnel should immediately:

- **Call 9-1-1**
- **Contact Parent/Guardian**
- **Other:** _____

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

Physicians Signature: _____ **Date:** _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Continued Cardiac Plan for (Student NAME) _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

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_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

Parent/Guardian: _____ Cell: _____
_____ Work _____
Parent/Guardian: _____ Cell: _____
_____ Work: _____

ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

CYSTIC FIBROSIS

SCHOOL YEAR:_____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Symptoms:

- ☐ Persistent coughing, at times with mucus
- ☐ Wheezing or shortness of breath
- ☐ Recurrent respiratory infections
- ☐ Fatigue
- ☐ Upset stomach

Medications taken at home: _____

Medications needed at school: ☐ Yes ☐ No If yes please list: _____

Enzymes needed at school: ☐ Yes ☐ No Enzyme brand name: _____

 # to be taken with snack: _____ **# to be taken with meals:** _____

For Self Administration of Enzymes:
It is my professional opinion that _____ (Student name) ☐ should ☐ Should **NOT** carry
and use enzymes by him/herself.

Special equipment needed at school? ☐ Yes ☐ No _____

Dietary modifications? (please list) _____

Activity restrictions (excuse from physical education requires a physician's note) _____

Fluids needed with physical activity? ☐ Yes ☐ No What type is needed? _____

Other modifications needed? (i.e. frequent bathroom breaks): _____

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

Physician's Signature: _____ **Date:** _____

Rev. 06/2022

ST. JOHNS COUNTY SCHOOL DISTRICT

Continued Cystic Fibrosis Plan for (Student NAME) _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐
Does your child function independently with medication administration? Yes ☐ No ☐
Are there any activity restrictions for your child? Yes ☐ No ☐
If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

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_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**

Parent/Guardian _____ Cell: _____

Work: _____

Parent/Guardian _____ Cell: _____

Work: _____