Physician's Signature: (Required)

ASTHMA Medical Management Plan SCHOOL YEAR: Student Name: Date of Birth: Phone #: _____ Physician's Name: Fax #:_____ Address: List Known ALLERGIES: Identify the things that start an asthma episode (check all that apply to the student) Exercise Strong odors of fumes Respiratory infections Carpets in the room Chalk Dust Change in temperature Food Animals Pollens Other Molds **Daily Medication Plan** Amount/Dose When to use Name of Medication 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** Amount/Dose When to use Name 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: Date: (Required)

Date:

Continued Asthma Plan for (Student NAME)		
Is your child compliant with their current treatment Does your child function independently with medica Are there any activity restrictions for your child? If yes, please list:	ation administration?	Yes No No Yes No No
PARENT/GUARDIAN to Complete: Aut Nurse to Share Information		,
I authorize my child's school nurse to assess my child as with my child's physician as needed throughout the schoplan for my child. I understand I may withdraw this author As the parent or guardian of the student named above, I rof medication/treatment prescribed for my child. I understand that under provisions of Florida Statue 10 administration of medication when the person administration would have acted under the same or similar circumstance listed above if there are any questions or concerns about authorize the physician to release information about this contents.	nol year. I understand this is for the purportization at any time and that this authorizatequest that the principal or principal's designated that the shall be no liability for circuiting such medication acts as an ordinates. I also grant permission for school per the medication. I have read the guidelines	ose of generating a health care tion must be renewed annually. gnee assist in the administration vil damages as a result of the rily reasonable, prudent person sonnel to contact the physician
	*	
Parent/Guardian Signature	Print Name	Date
Parent/Guardian:	Cell:	
	Work:	
Parent/Guardian:	Cell:	
	Work:	

Medical Management Plan

SEIZURE DISORDER

SCH	OOL YEAR:			
Stude	ent Name:			
Physi	ician's Name:		Phone #: _	
Addr	ess:		Fax #: _	
List K	nown ALLERGIES:			
Туре	of seizures:			
Pleas	e list all medications (HOMI			
	nedications needed during sch	ool hours? Yes N	No	
	Name of medication	Prescribed Dose/Route		When to use
	stat or Midazolam is order Id be given:		eizures in a row	Minutes into seizure
Are t	S used? (if yes please instruct) here activity limits? (if yes pleated) tective equipment required	? (if yes please describe) Yes	□ No ====	
Nursi	ng services are recommended	for the care of this student du	ring the school day.	
Phys	sicians Signature:			Date:
For P	arent to Complete:			
	When was the last seizure?			
	At what age did the seizure	activity begin?		
3.	Describe the seizure?			
4.	How often do seizures occu	r?		
5.	How long do the seizures no	ormally last?		
6.	Has the seizure ever lasted	longer than 5 minutes?	Yes No	
	If yes, how was it handled?			

Con	tinued Seizure Plan for (Student NAME)					
7. 8.	Does your child lose bowel or bladder control during Has your child ever turned blue or stopped breathing If yes, how was it handled?		Yes	No No	3 2.7	
9.	Has your child ever required hospitalization due to a If yes, please explain:	seizure	Yes 🗌	No 🗌		
10.	Is there anything that seems to trigger a seizure? If yes, please list:		Yes	No 🗌		
11.	Does your child experience an aura before a seizure? If yes, please explain:		Yes	No		
Othe	r considerations that will assist the school in providing care	for your child:				
Does Are t If yes PARE I author physic I may	ur child compliant with their current treatment regime? your child function independently with medication adminithere any activity restrictions for your child? , please list: INT/GUARDIAN to Complete: Authorization for Health Carporize my child's school nurse to assess my child as it relates to his/her spian as needed throughout the school year. I understand this is for the pwithdraw this authorization at any time and that this authorization must be parent or guardian of the student named above, I request that the	re Provider and Schoo pecial health care needs a burpose of generating a h t be renewed annually.	and to discuss t ealth care plan	Yes Yes Share Informa hese needs with for my child. I u	my ch	tand
medic I unde medic or sim concer	ation/treatment prescribed for my child. Instand that under provisions of Florida Statue 1006.062, there shall be ation when the person administrating such medication acts as an ordinalization acts are acts and acts are acts are acts and acts are acts are acts are acts and acts are acts and acts are acts are acts are acts and acts are acts are acts are acts and acts are acts are acts and acts are acts are acts and acts are acts are acts are acts are acts and acts are acts are acts are acts and acts are acts are acts and acts are acts are acts and acts are acts are acts are acts and acts are acts are acts acts are acts and acts are acts and acts are acts and acts are acts are acts and acts are acts are acts and acts are acts and acts are acts are acts and acts are acts are acts and acts ar	e no liability for civil dan arily reasonable, prudent contact the physician lis	nages as a resu person would I ted above if tl	ilt of the adminis have acted under here are any qu	stratio the s estion	on of same
	Parent/Guardian Signature	Print Name	 .	Dat	e	
Paren	t/Guardian	Cell:				
		Work:				
Paren	t/Guardian:	Cell:				
		Work:				

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	al Managen Year:	nent Plan				ALLERGY
Student Na	ame:		Date o	of Birth:		
Physician's						
Address:						
Address.	-			Γαλ π,		
Allergy To				Asthma:		No or if student has asthma*
STEP 1:	TREATMENT			,		
Symptoms:			** .			ed Medication**
If a food all	organ bas baan ing	rostod hut no sumentone		oe determ		authorizing treatment* Antihistamine
MOUTH:		sested, but no symptom or swelling of lips, tongo		-	Epinephrine Epinephrine	Antihistamine
SKIN:		swelling of the face or		\rightarrow	Epinephrine	Antihistamine
GUT:		al cramps, vomiting, dia			Epinephrine	Antihistamine
THROAT*:		oat, hoarseness, hacking			Epinephrine	Antihistamine
LUNG:		th, repetitive coughing			Epinephrine	Antihistamine
HEART		w blood pressure, fainti			Epinephrine	Antihistamine
Other:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , ,	,		Epinephrine	Antihistamine
	s progressing (seve	eral of the above areas	affected), give		Epinephrine	Antihistamine
		ne severity of symptoms can		1		
Epinephrin		EpiPen®	Auvi-Q		• •	rine Auto Injector
DOSAGE	(circle one)	0.15 mg OR 0.30mg	0.15 mg OR 0.30 mg		0.15 mg C	R 0.30 mg
Antihistam	ine/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	s Signature: (Requi	ired)			Date:	

Continued Allergy Plan for (Student NAME)		
IMPORTANT: Asthma inhalers and/or antihistami anaphylaxis.	nes cannot be depended on to rep	lace epinephrine during
Is your child compliant with their current treatmen Does your child function independently with medic Are there any activity restrictions for your child? If yes, please list:	t regime? cation administration?	Yes No No Yes No No
PARENT/GUARDIAN to Complete: Authorization	n for Health Care Provider and Sch	nool Nurse to Share Information
I authorize my child's school nurse to assess my child as it relat physician as needed throughout the school year. I understand I may withdraw this authorization at any time and that this aut As the parent or guardian of the student named above, I remedication/treatment prescribed for my child. I understand that under provisions of Florida Statue 1006.062 medication when the person administrating such medication are or similar circumstances. I also grant permission for school persabout the medication. I have read the guidelines and agree condition to school personnel.	this is for the purpose of generating a healt thorization must be renewed annually. Equest that the principal or principal's dest. It there shall be no liability for civil damage cts as an ordinarily reasonable, prudent personnel to contact the physician listed above.	th care plan for my child. I understand signee assist in the administration of es as a result of the administration of son would have acted under the same of these are any questions or concerns.
Parent/Guardian Signature	Print Name	Date
Parent/Guardina Contact Information		
Parent/Guardian:	Cell:	
	Work:	
Parent/Guardian:	Cell:	
	Work:	

Medical Management Plan

BLEEDING DISORDERS

SCHOOL YEAR:				
Student Name:	Da	ate of Birth:		
		Phone #:		
A.I.I.				
List Known ALLERGIES:				
Brief Description of bleeding of	disorder:			
Medications: (Please list and r	note that IV medications are not give	en by school perso	nnel.)	
Restrictions: (Please list restri	ctions including physical education a	activities, a doctor	s signature is re	equired)
First Aid Treatment for Bleeding: • Apply ice to the site Other:	• Call 911		Parent/Guardian	
Nursing services are recommended Physicians Signature:	for the care of this student during the school		Date:	
	ete: Authorization for Health Care Pr		Nurse to Share I	information
I authorize my child's school nurse to as physician as needed throughout the sch I may withdraw this authorization at an As the parent or guardian of the studendication/treatment prescribed for m I understand that under provisions of medication when the person administrator similar circumstances. I also grant per	ssess my child as it relates to his/her special hea nool year. I understand this is for the purpose o y time and that this authorization must be renev lent named above, I request that the principa	Ith care needs and to distinguished annually. If or principal's designe lity for civil damages as prable, prudent person by sician listed above if the	scuss these needs we plan for my child. e assist in the adm a result of the adm would have acted un ere are any question	rith my child's I understand sinistration of sinistration of ider the same as or concerns
Parent/Guardian Signa	ature Prin	nt Name		Date
Are there any activity restriction	ndently with medication administration	?	Yes Yes Yes	No No
Parent/Guardian:	Cell:	-		
Parent/Guardian:	Work Cell: Work			

Physicians Signature:

Medical Management Plan CARDIAC School Year:_____ Date of Birth: Student Name: Phone #: Physician's Name: Fax #:_____ Address: List Known ALLERGIES: Brief description of condition: Current Medications: Name: Dosage/Rout: School | Home | Name: Dosage/Rout School Home Special Equipment: School Home | Other: _____ Symptoms child may demonstrate: Tires easily SOB Pain 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

Date:

Continued Cardiac Plan for (Student NAME)		
Is your child compliant with their current treatment of Does your child function independently with medicate Are there any activity restrictions for your child? If yes, please list:		Yes No No Yes No No
PARENT/GUARDIAN to Complete: Authorization f	or Health Care Provider and School N	urse to Share Information
I authorize my child's school nurse to assess my child as it relate physician as needed throughout the school year. I understand the may withdraw this authorization at any time and that this authorization at any time and that this authorization at any time and that this authorization above, I request that the principal or principal's designee I understand that under provisions of Florida Statue 1006.062, medication when the person administrating such medication act or similar circumstances. I also grant permission for school personabout the medication. I have read the guidelines and agree to condition to school personnel.	nis is for the purpose of generating a health care corization must be renewed annually. As the particle assist in the administration of medication/treating there shall be no liability for civil damages as as an ordinarily reasonable, prudent person wormel to contact the physician listed above if the	plan for my child. I understand I arent or guardian of the student ment prescribed for my child. a result of the administration of yould have acted under the same are any questions or concerns
Parent/Guardian Signature	Print Name	Date
Parent/Guardian:	Cell:	
Do nomb/Cupadia a	Work	
Parent/Guardian:	Cell: Work:	

CYSTIC FIBROSIS Medical Management Plan SCHOOL YEAR: Date of Birth: Student Name: Phone #: Physician's Name: Fax #: _____ Address: List Known ALLERGIES: Persistent coughing, at times with mucus **Fatigue Symptoms:** Wheezing or shortness of breath **Upset stomach** Recurrent respiratory infections Medications taken at home: No If yes please list: Yes Medications needed at school: No Enzyme brand name: Yes Enzymes needed at school: # to be taken with meals: # to be taken with snack: For Self Administration of Enzymes: should | Should NOT carry It is my professional opinion that Student name 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:

Continued Cystic Fibrosis Plan for (Student NAME)	
Is your child compliant with their current treatment reg Does your child function independently with medicatio Are there any activity restrictions for your child? If yes, please list:		Yes No No Yes No No
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 physician as needed throughout the school year. I understand this I may withdraw this authorization at any time and that this authoriz As the parent or guardian of the student named above, I reque medication/treatment prescribed for my child. I understand that under provisions of Florida Statue 1006.062, the medication when the person administrating such medication acts a or similar circumstances. I also grant permission for school per concerns about the medication. I have read the guidelines and ag this condition to school personnel.	is for the purpose of generating a health ca cation must be renewed annually. Ist that the principal or principal's designe ere shall be no liability for civil damages as is an ordinarily reasonable, prudent person to sonnel to contact the physician listed abo	re plan for my child. I understand the assist in the administration of a result of the administration of would have acted under the same we if there are any questions or
Parent/Guardian Signature	Print Name	Date
Parent/Guardian	Cell:	
	Work:	
Parent/Guardian	Cell:	
	Work:	