ST. JOHNS CLASSICAL ACADEMY

ALLERGY MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

(Must be filled out completely by Physician/Healthcare Provider)

SCHOOL HEALTH SERVICES SCHOOL YEAR:_____

Scholar Name: _____ DOB: _____ Grade: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

ALLERGY TO: _____

HISTORY OF PREVIOUS ALLERGIC REACTION? ☐ Yes ☐ No **STUDENT HAS ASTHMA**: ☐ Yes (*higher risk for a severe reaction*) ☐ No

DIETARY MODIFICATIONS/FOOD ALLERGIES: ☐ Yes ***(If yes, complete page 2)*** ☐ No

SEVERE ALLERGY TO: _____

☐ **If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.**

☐ **If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.**

SYMPTOMS AND MANAGEMENT OF ANAPHYLAXIS

Any SEVERE SYMPTOMS after suspected or known ingestion and/or exposure:

One or more of the following:

LUNG:	Shortness 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, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Monitor scholar**.**
4. Give additional medications as ordered*
   - Antihistamine
   - Inhaler (bronchodilator) if asthmatic
5. **Antihistamines & inhalers (bronchodilators) are not to be depended upon to treat a severe reaction (anaphylaxis). Use epinephrine first. If symptoms persist, a second dose of epinephrine may be given 5 minutes or more after initial dose (if available).**

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 scholar; alert healthcare professionals and parent.
3. If symptoms progress (see above), USE EPINEPHRINE
4. Monitor student**.**

EMERGENCY MEDICATIONS *Medications must go with scholar if he/she is off school grounds (i.e. band or field trips, sporting events, etc.)

☐EPINEPHRINE	☐ANTIHISTAMINE	☐RESCUE INHALER
Specify medication name and directions: _____ _____	**Specify medication name and directions**: _____ _____	**Specify medication name and directions**: _____ _____
Location of Epinephrine: ☐School Nurse in Health Room ☐Carried by Scholar ☐Kept with Teacher/Staff	**Location of Antihistamine**: ☐School Nurse in Health Room ☐Carried by Scholar ☐Kept with Teacher/Staff	**Location of Rescue Inhaler**: ☐School Nurse in Health Room ☐Carried by Scholar ☐Kept with Teacher/Staff
Scholar may carry and/or self-administer: ☐Yes ☐No	**Scholar may carry and/or self-administer**: ☐Yes ☐No	**Scholar may carry and/or self-administer**: ☐Yes ☐No

_____ **Physician/Provider Signature (Required)** **Date**

OFFICE STAMP

_____ **Parent/guardian Signature (Required)** **Date**

_____ **School Nurse Signature (Required)** **Date**

Copies of Allergy MMP-EAP given to:

☐ Parent ☐ Teacher ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th

☐ PE ☐ Cafeteria ☐ Coach ☐ Music ☐ Art ☐ Other _____

This document serves as both the Allergy Medical Management Plan and Allergy Emergency Action Plan if completed and signed by the Healthcare Provider.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Scholar Name: _____ DOB: _____

Parent Name: _____ Phone: _____

1. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/or accommodation. **A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.**

☐ Participant has a food allergy, not considered a disability. Food preferences are not an appropriate use of this form. Please note the food to be omitted below so the participant's meal account can be noted. **A medical authority's signature is not needed and a parent/guardian may complete this form.**

2. The participant's disability or medical condition requiring a special meal or accommodation:

3. If participant has a disability, provide a brief description of his/her major life activity affected by the disability (e.g., Allergy to peanuts causes life-threatening reaction):

4. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

5. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):

A. Foods To Be Omitted	B. Suggested Substitutions

6. Signature of Recognized Medical Authority*	7. Printed Name	8. Telephone Number	9. Date
10. Signature of Parent or Guardian	**11. Printed Name**	**12. Telephone Number**	**13. Date**

***For this purpose, a recognized medical authority is a licensed physician, physician assistant, or nurse practitioner.**

Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

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