Pasco County Schools
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Dear Parent/Guardian:

According to District School Board of Pasco County Policy 5335, students who receive medication, health procedures or have special dietary needs (e.g. Diabetes Management, Diastat, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement) at school shall provide **annual** parental and healthcare provider authorization for the administration of medications and procedures.

If your child plans to carry his/her own supplies and/or perform any of the above medical procedures independently and without supervision during the next school year:

- Please return the *Authorization to Carry and Self Administer Diabetes Medication/Procedure, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement* form (available on the district website) signed by physician, parent and student **on or before the first day of school.**
- Please make sure your child carries all necessary supplies (Diabetes equipment or medication, Inhaler, Epipen, and/or Pancreatic enzyme supplement) at all times.

If your child may/will require assistance with administration of medication and/or procedures at any time during the next school year:

- Depending on your child's condition, please return either the *Severe Allergy (Anaphylaxis)* ***or*** *Seizure* ***or*** *Diabetes Medical Management Plan* form (found below) completed and signed by physician and parent **on or before the first day of school.**
- Please return the *Authorization for Medication Administration* form (available on the district website) for any medication that will need to be administered for your child **on or before the first day of school.** This form should be completed and signed by parent.
- Please provide the school clinic with all necessary supplies. Remember that medication must be brought to school by the parent / guardian (e.g. Insulin, Glucagon, Diastat, Inhaler, Epipen, etc.).

If your child may/will require assistance with special dietary needs during the next school year:

- Please submit completed *Diet Order Request* and/or *Severe Allergy (Anaphylaxis) Medical Management Plan* forms. The *Diet Order Request Form* will be reviewed/evaluated by the Food & Nutrition Services District Office on a case-by-case basis. Since school sites are not allergen free facilities, it may be beneficial to send a meal from home for the first few weeks of school.

While not all students' requests will be accommodated, our online menus identify common allergens and carbohydrate/nutrient information to assist you and your child in navigating their meal options. You can access this helpful tool online at https://schools.mealviewer.com/results/pasco%20county or download the mobile app on your smartphone or tablet.

Please feel free to call your child's School Nurse if you have any questions or would like to discuss your child's health status.

Thank you.

Pasco County School Health Services Program

4/2022

Pasco County Schools

Anaphylaxis Medical Management Plan

Student Name:	D.O.B:	School Year:
Allergy to:	Asthma: _____Yes *higher risk for severe reaction _____ No	
Other health problems besides anaphylaxis	Other medications:	

Symptoms of Anaphylaxis

Mouth	Itching, swelling of lips and/or tongue
Throat*	Itching, tightness/closure, hoarseness
Skin	Itching, hives, redness, swelling
GI:	Vomiting, diarrhea, cramps
Lung*	Shortness of breath, cough, wheeze
Heart*	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
*Some symptoms can be life threatening. **ACT FAST!**

Emergency Action Steps

DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

_____ Epi-pen Jr. (0.15 mg.) _____ Epi-pen (0.3 mg.)
_____ Adrenaclick (0.15 mg.) _____ Adrenaclick (0.3 mg.)
_____ Auvi-Q (0.15 mg.) _____ Auvi-Q (0.3 mg.)

Epinephrine injection, USP Auto-injector – authorized generic
_____ (0.15 mg.) _____ (0.3 mg.)

Other (specify): _____

ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!

2. Call 911 immediately! Call emergency contacts next.
3. Emergency contact #1: home_____work_____cell_____

   Emergency contact #2: home_____work_____cell_____

Parent has provided emergency medication to school: ☐ YES ☐ NO

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Print, type, or stamp Physician's Name & Information: _____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Adapted from American Academy of Allergy, Asthma & Immunology www.aaaai.org.

Revised 5/2022

Food Allergy Assessment Form

Student Name: _____ **Date of Birth:** _____ **Date:** _____

Parent/Guardian: _____ **Phone:** _____ **Cell/work:** _____

Grade_____

Health Care Provider (name) treating food allergy: _____ Phone: _____

Is your child's food allergy *life-threatening*? ____ No ____ Yes
(If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

____ Peanuts
____ Peanut or nut butter
____ Peanut or nut oils
____ Fish/shellfish
____ Soy products
____ Tree nuts (walnuts, almonds, pecans, etc.)
____ Eggs
____ Milk

Please list any others: _____

How many times has your student had a reaction? ____ Never ____ Once ____ More than once, explain:

_____

When was the last reaction and please describe symptoms?

_____

Are the food allergy reactions: ____ staying the same ____ getting worse ____ getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? (*Check all that apply*)

____ Eating foods ____ Touching foods ____ Smelling foods ____ Other, please explain: _____

_____

What are the signs and symptoms of your student's allergic reaction? (*Be specific; include things the student might say.*)

_____

_____

How quickly do the signs and symptoms appear after exposure to the food(s)?

____ Seconds ____ Minutes ____ Hours ____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

____ No ____ Yes, explain: _____

Does your student understand how to avoid foods that cause allergic reactions? ____ Yes ____ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? ____ No ____ Yes

Does your student know how to use the treatment? ____ No ____ Yes

Please describe any side effects or problems your child had in using the suggested treatment:

_____

_____

If you intend for your child to eat school provided meals, have you filled out a Medical Statement for Special Meals form for school (located on the District website)?

____ Yes

____ No, I need to get the form, have it completed by our health care provider and return it to school.

If medication is to be available at school, has the physician filled out a Severe Allergy Medical Management form for school (located on the District website)?

____ Yes

____ No, I need to get the form, have it completed by our health care provider and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

____ Yes

____ No, I need to get the medication/treatment and bring it to school.

What would you like us to do at school to help your student avoid problem foods?

_____

Is it medically necessary for your child to sit at a separate table in the lunchroom?

____ Yes

____ No

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

____ Yes

____ No

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

DO NOT WRITE IN THIS AREA
9532049620

School Year: _____ *(Año escolar)*

PART A Parent / Guardian: Complete Items 1 - 16 *(Padre/madre/tutor: complete la información en los espacios 1 al 16)*

1) **Student ID#** *(Numero de estudiante)* | 2) **Student's Last Name** *(Apellido)* | 3) **Student's First Name** *(Nombre del estudiante)* | 4) **Date of Birth** *(Fecha de nacimiento)*

5) **School** *(Escuela)* | 6) **Grade** *(Grado)* | 7) **Student assigned in:** ☐ PreK/EHS ☐ PreK VE ☐ Charter ☐ K-12

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

8) Name *(Nombre)* | 9) Phone Number *(Teléfono)* | 10) Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

11) E-mail Address (We will use this to send acknowledgement and details of your child´s menú plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

12) **Meals Eaten at School**
(Los alimentos que su niño(a) consumirá en la escuela)
☐ **Breakfast** *(Desayuno)* ☐ **Snack** *(Meriendao)*
☐ **Lunch** *(Almuerzo)* ☐ **None** *(Nada)*

13) **Allowable Parent Request:** *(Solicitud de los padres)*
☐ **Lactose Intolerance** *(intolerancia a lactosa) (Lactaid Milk needed) (necesita leche Lactaid)*
Mark if student cannot eat (marque si no puede comer) ☐ **Cheese** *(queso)* ☐ **Yogurt** *(yogur)*
☐ **Cultural/Religious Preference** *(preferencias culturales/religiosas)*
Mark if student cannot eat (marque si no puede comer) ☐ **Pork** *(carne de cerdo)* ☐ **Beef** *(carne de res)* ☐ **Other** *(otro)* _____
☐ **Other Condition (Must be diagnosed by physician using Part B)** *(Otro condición- debe ser diagnosticado por un médico en la parte B)*

14) **Does the student have an identified disability (IEP or 504 Plan)?**
¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ Yes *(Si)* ☐ No

15) **I consent to the exchange of information between the physician and school, as needed.**
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)
Parent / Guardian Signature (required for processing) *(Firma del padre/madre/tutor - requerido para ser procesado)* X _____ **Date** *(Fecha)* _____

16) **Parent/Guardian: It is REQUIRED that this completed form is returned to the cafeteria manager. All further changes to the child's diet must be made by a physician on a new form with the exception of lactose intolerance or cultural preference. The manager will add the alert to the cashier system & return the form to the District FNS Office for consideration.**
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. El gerente de la cafetería añadirá un alerta en el sistema de cajeros y devolverá la forma a las oficinas de Alimentos y Nutrición del Distrito)

*Information regarding major allergens and nutrient/carbohydrate information are available for review at http://schools.mealviewer.com/district/pascocounty
(Ver información sobre alergenos y nutrientes/carbohidratos en http://schools.mealviewer.com/district/pascocounty)

PART B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 20 *(17 al 20 - Esta sección para ser completada por el médico solamente.)*

17) **Student Diagnosis or Condition** ☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy ☐ Other (Specify) _____
**** Students with life threatening food allergies must have an emergency action plan in place at school.***

18) **Please check all food(s) to omit from child's diet during the school only (not to be used as a medical history):**

DAIRY
- ☐ Fluid Milk. Substitute with ☐ lactose-free milk ☐ soy milk ☐ water
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Ice Cream
- ☐ Yogurt
- ☐ Baked goods with any dairy listed as an ingredient

EGG
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ Baked goods with any egg listed as an ingredient

WHEAT / GLUTEN
- ☐ Recipes with any wheat listed as an ingredient
- ☐ Recipes with any gluten containing grain listed as an ingredient

FISH OR SHELLFISH
- ☐ Fish ☐ Shellfish

PEANUTS OR TREE NUTS
- ☐ Peanuts
- ☐ Tree Nuts

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn products listed as an ingredient

SOY
- ☐ Soy Lecithin
- ☐ Soy Protein (concentrate, hydrolyzed, isolate)
- ☐ Recipes with any soy listed as an ingredient

OTHER
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

_____
_____

19) **Does the student have a disability, medical condition, or severe food allergy warranting a special diet?** ☐ **Yes** If "YES", specify disability below
A disability is defined as a physical or mental impairment which substantially limits one or more major life activities. ☐ **No** **If "NO", A SPECIAL DIET IS NOT WARRANTED.**

Disability (specify) _____ Describe major life activities affected _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

20) **LICENSED PHYSICIAN'S INFORMATION** ***Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.***

Medical Authority Signature X _____ Date __ - __ - 202_

Medical Office Stamp (Required for processing)

Medical Authority Printed Name _____

Pasco County Schools
General Guidelines for Administration of Medication at School

1. Administration of medication during school hours should occur only when medication schedules cannot be adjusted to provide for administration at home.
2. Medication will be administered by personnel trained by the registered professional school nurse.
3. Medication must be brought to school by the parent/guardian in the original prescription container with the original prescription label containing the following information:
    a. Student's name.
    b. Name of medication (Only FDA approved [regulated] medications will be administered at school, i.e., no herbal medications, supplements, essential oils, etc.).
    c. Dosage prescribed (If the dosage changes a new prescription bottle or script must be provided).
    d. Time of day to be taken (e.g., 9:45 AM) or if the medication is ordered as needed, how many hours in between doses (e.g., every 2 hours).
    e. Physician's name.
    f. Special instructions.
    g. Date of prescription (current, within one year).
4. No more than a month's supply (30-day supply) of medications should be brought to school by a parent/guardian, at one time.
5. All medications, whether self-carry or maintained in the clinic must be entered into the Health – Clinic System Medication Order Form. Medications administered in the clinic will be recorded on the Medication Administration Record (MAR) / Medication Inventory Record (MIR) and in the Health – Clinic System. Any changes to the time or dosage requires a new MAR / MIR to be created and a discontinuation of the Medication Order Form and a new Medication Order Form will need to be created with the updated information.
6. Medication received must be counted by at least two trained staff (additional signature from parent preferred). The amount and date received is to be recorded in the Health – Clinic System and on the individual *Medication Inventory Record* form.
7. A *Parent/Guardian Permission* form must be completed by the parent/guardian, granting the school permission to assist in the administration of such medication and which shall explain the necessity for such medication to be provided during the school day, including any occasion when the student is away from school property on official school business. Parents may not need to complete this form if authorization is provided (signed by parent/guardian) via student's *Medical Management Plan*.

*Note: It is preferred that the parent/guardian of a student obtain the needed dose(s) of medication for field trips in a separate, appropriately labeled prescription container. If that is not possible, the entire bottle of medication must be sent with a trained person to be administered on the field trip. Under no circumstances may medication be transferred from one container to another by anyone other than a registered pharmacist (no medications are to be placed in envelopes or baggies).

8. FDA approved (regulated), over-the-counter medication will not be administered at school, unless accompanied by a physician's statement, dated within the current school year (exception: *Healthy Student Program*). Over-the-counter medications must be brought to school by a parent/guardian in the original, unopened container.
9. Students will be allowed to carry metered dose asthma inhalers, pancreatic enzyme supplements, epinephrine auto-injectors and/or diabetes supplies, medication, and equipment with a completed *Authorization to Carry and Self Administer* form from their parent/guardian and physician (F.S.1002.20 (3)(h), (i), (k) and/or (j)).
10. If a student is participating in an after-school activity and has emergency medication in the clinic, the registered professional school nurse and clinic assistant must be notified by the parent/student.
11. No prescription narcotic analgesics will be administered at school.
12. Parental and healthcare provider authorization for the administration of medications and treatments is required each school year.
13. All medications must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent/guardian or designee, unused and unclaimed medication will be destroyed following proper disposal procedures. Legal Authority: section 1006.062, F.S.A.

Legal Authority: section 1006.062, F.S.A.

AUTHORIZATION TO CARRY AND SELF ADMINISTER ASTHMA INHALER, EPI-PEN, AND/OR PANCREATIC ENZYME SUPPLEMENT

Student Name (print) _____ Parent / Guardian Name (print) _____

Student Number _____ Grade _____ Name of School _____

Name of Medication _____

In order for your child to carry and administer his/her own inhaler/epi-pen/or pancreatic enzyme supplement (PES), you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out IN ADDITION to the Medical Management Plan, which further sets forth the parental authorization and licensed prescriber's acknowledgement concerning the self-administration of medication.

A. To be completed by the Florida licensed healthcare provider:

_____ has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me, in the student's Medical Management Plan, without assistance. This student should be allowed to carry and use the equipment/medication(s) listed above.

(Licensed Prescriber's Signature) (Phone Number) (Date)

B. To be completed by the parent/legal guardian

I request that my child _____ be permitted to carry and self-administer the above-prescribed medication(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child acknowledges and agrees that the medication is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will immediately notify an employee of the District School Board of Pasco County if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of the District School Board of Pasco County if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that the District School Board of Pasco County assumes no responsibility whatsoever for the maintenance, storage, dosage, replacement if damaged or lost, or administration of the above student's inhaler/epi-pen/or PES. I furthermore agree to indemnify and otherwise hold harmless the District School Board of Pasco County, its employees and volunteers for any and all liability with respect to the student's use or misuse of such medication pursuant to s. 1002.20(3)(h),(i) and/or (k).

Date _____ Parent / Guardian Signature _____

Date _____ Student Signature _____

Revised 5/2015

Pasco County Schools

Annual Student Medication Administration Record (MAR)

Student Name: _____ Student #: _____ Grade: _____ DOB: _____ School: _____

Medication: _____ Dosage/time(s) to be given: _____ Exp. Date: _____

Allergies: _____ Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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May																															
June																															
July																															

Codes: A = Absent N = Medication not sent by parents O = No Show

Teacher / Extension: _____

Initials and name of persons administering:

_____ _____

_____ _____

Note: This form must be saved for 7 years

Attach student photo if available

Updated: 02/2023

Medication Inventory Record

Transfer amount of medication from Previous month: __________

Student name: ______________________ Student #: __________ Grade: _____ DOB: __________

Medication: ______________________ Dosage: ______________ Time: ______________

Date	Time	Start Count	Plus	New Amt Rec'd	Total	Minus	Amt Given	Minus	Wasted or returned / Field Trip	Actual Total W / H	Staff Initials	Staff Initials	Parent Initials	Action Taken Code	Comments	RN
			+			-		-								
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Codes: R = RN Notified, A = Admin Notified, P = Parent Notified, D = Dropped Med, E= Expired Med, F = Field Trip, O = Other

Initials and Signature of persons counting medications
