Florida Virtual SCHOOL™

Anaphylaxis Emergency Care Plan

This form is to be filled out and signed by a physician (medical doctor). If there is additional information regarding your child's anaphylactic needs that do not fit on this document, all additional pages must be submitted on the physician's letterhead and each page signed by the physician. Please submit the care plan and the medication authorization form, also completed by a physician, to studenthealth@flvs.net. All documents are required for the care plan to be put in place.

Student Name: _____ **DOB:** _____ **Student ID:** _____ **Grade:** _____

Parent/Guardian: _____ **Phone:** _____

Other Emergency Contact: _____ **Phone:** _____

Part to be completed by a Physician:

Physician Name: _____ **Phone:** _____ **Date:** _____

Allergies: _____

SEVERE ALLERGY TO: _____

Asthmatic: ☐ YES ☐ NO * Higher risk for severe reaction

Symptoms: (Physician, please circle all symptoms that require Epinephrine Auto-Injector administration)

Mouth	itching, tingling or swelling of the lips, tongue, mouth
Throat	tightening of throat, hoarseness, hacking cough
Skin	hives, itchy rash, swelling of the face or extremities
Gastrointestinal	nausea, abdominal cramps, vomiting, and diarrhea
Lung	difficulty breathing, shortness of breath, repetitive coughing, wheezing
Heart	weak or thready pulse, low blood pressure, fainting, paleness
Other	

If the student is showing the signs and symptoms of having an anaphylactic reaction as described above, then give Epinephrine Auto-Injector or other emergency medication as directed per this Emergency care plan and Medication Authorization Form.

Physician, please select by checking dosage to be administered.

- ☐ Epinephrine Auto-Injector (0.15mg epinephrine)
- ☐ Epinephrine Auto-Injector (0.3mg epinephrine)
- ☐ Other:_____

Emergency Actions:

1. Give emergency rescue medication per this Emergency Care Plan and Medication Authorization Form.
2. Call 911 IMMEDIATELY after
3. Call Parents/Emergency Contact
4. Stay with student and reposition for optimal breathing
5. Perform CPR if necessary

Physician Signature: _____ Physician Stamp:

I certify that I am the parent or guardian of the above-named student, I approve this emergency care plan and understand that this plan will be shared with necessary Florida Virtual School ("FLVS"), state testing site personnel, county health department, medical personnel, and their employees and volunteers to ensure the safety of the student with a health condition. I authorize the above-medication to be administered as described or prescribed during FLVS in-person events or state testing. With full understanding of the risks involved, on behalf of myself and my child, I hereby release, hold harmless and indemnify FLVS, state testing site personnel, county health department, medical personnel, and their employees and volunteers for damages, payments, fees, and any other monetary obligations and indebtedness of any form caused by or arising from my child's personal injury or death arising from my child's self-administration of medication. I agree that I am responsible for providing the school with my emergency contact information, and my child's Emergency Care Plan, medication, and Medication Authorization form completed by the physician. By signing this form, I acknowledge that I have read and understand this form in its entirety.

Parent/Guardian Signature: _____ Date: _____