Asthma 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 asthma 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: _____

Allergies: _____

Asthma triggers: _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Green: Student feels well. Peak flow is within normal range.	**Symptoms:** No breathing issues. No wheeze or cough. Student can do usual activities.
	Daily medication: **Name:** **Dose:** **Time taken:**
	Medication for exercise: **Name:** **Dose:** **When to take:**
Yellow: Peak flow is decreased (50-79% of personal best)	**Symptoms:** Some breathing issues. Cough, chest tightness, wheezing and some difficulty performing usual activities. Other: _____
	Rescue medication to treat symptoms: **Name:** **Dose:** **Frequency:**
Red: Emergency! Peak flow meter less than 50% of personal best	**Symptoms:** Difficulty catching their breath, wheezing, coughing, or rapid breathing. Rescue medication is not improving symptoms. Cannot do usual activities. **Call 911 if** in respiratory distress, difficulty walking or standing, lips of fingernails are blue, or: _____
	Rescue medication to treat symptoms: **Name:** **Dose:** **Frequency:** **Name:** **Dose:** **Frequency:**

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List the equipment required for administering the students' medication:

_____

_____

FL statute 1002.02 (*h*)2 *"Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator and components on their person while in school."*

Does the student have the parent/guardian and physician approval to self-administer and carry this medication on their person during an in-person event?

☐ No

☐ Yes, then sign below (physician signature required by state statute and FLVS Policy).

Parent/Guardian Signature: _____

Physician Signature: _____

Emergency Actions:

1. Give medication and/or rescue medication per this Emergency Care Plan and Medication Authorization Form.
2. Call Parents/Emergency Contact.
3. Stay with student, position them for optimal breathing, calm and direct them to perform slow, deep breaths.
4. Reassess students' breathing status 15 minutes after rescue medication given, if no improvement or worsening call 911. Update Parents/Emergency Contact.
5. Continue to monitor respiratory status and perform CPR, if necessary, until emergency services arrive.

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:** _____

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