Mountain View Whisman School District

EMERGENCY HEALTH CARE PLAN (FOOD ALLERGY)

Student Name: _____ D.O.B: _____ Grade: _____ Room: _____
Address: _____ Home Phone #: _____
_____
Mother's Name: _____ Work Phone #: _____
Mobile #: _____
Father's Name: _____ Work Phone #: _____
Mobile #: _____
Doctor's Name: _____ Doctor's Phone #: _____

PHOTO

Hospital: _____ Insurance: _____ Policy #: _____

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ALLERGIC TO: _____

ASTHMATIC Yes* ☐ No ☐ *High risk for severe reaction

Usual Treatment: Not to eat or touch anything containing the above and their by-products

Actions for Teacher or Office to Take:

Teacher should stay with student

- **Call the office for help. Office to call 911. If not able to reach office, CALL 911 from classroom (dial 8-911) and send 2 students or an adult to the office with the emergency notification card.**
- **If outside, have someone run to the closest room and call the office for help and have the office call 911.**
- **Trained Staff to give medication as ordered by physician. If giving Epinephrine: Inject Epi-Pen in upper outer thigh. You do not have to remove any clothing. See the instructions attached.**
- **PLEASE WRITE THE TIME EPI-PEN WAS GIVEN _____.**

Signs of Emergency

Systems:	**Symptoms:**		**Give Checked Medication (TBD by physician authorizing treatment)**		
If food allergen has been ingested, but no symptoms			**Epinephrine**		**Antihistamine**
MOUTH	Itching & swelling of the lips, tongue, or mouth		**Epinephrine**		**Antihistamine**
SKIN	Hives, itchy rash, and/or swelling of the face and/or extremities		**Epinephrine**		**Antihistamine**
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea		**Epinephrine**		**Antihistamine**
THROAT	Itching and/or sense of tightness in the throat, hoarseness & hacking cough		**Epinephrine**		**Antihistamine**
LUNGS	Shortness of breath, repetitive coughing, and/or wheezing		**Epinephrine**		**Antihistamine**
HEART	"thready" pulse, "passing-out"		**Epinephrine**		**Antihistamine**
OTHER			**Epinephrine**		**Antihistamine**
If reaction is progressing (several of the above areas affected), give:			**Epinephrine**		**Antihistamine**

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I GIVE MY CONSENT FOR THIS INFORMATION TO BE SHARED WITH SCHOOL STAFF.

Parent's Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____
(REQUIRED)

Nombre del Estudiante: _____ Fecha de Nac.: _____ Grado: _____ Salón: _____