Bet Torah Kulanu Learning Program – 2019-20
60 Smith Avenue, Mount Kisco NY 10549 914-666-7595 914-864-1519 (fax)

Allergy Individualized Emergency Care Plan-
To be completed by Health Care Professional

Name: _____ Date of Birth: _____ Grade: ____

Allergy to: _____

History of Asthma? Yes_____ No_____

History of Anaphylactic Reaction? Yes_____ No_____

Extremely reactive to the following allergens: _____
THEREFORE:

[ ] 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.

Orders:
Epinephrine Brand or Generic: _____

Epinephrine Dose: (circle one) 0.15mg or 0.3 mg

Does the child self-carry?* (circle one) YES NO

Does the child self-administer? (circle one) YES NO

*If the child does not self-carry- submit epipen to be kept in the RS office.

DO NOT HESITATE TO ADMINISTER EPI-PEN OR CALL 911 IF PARENTS OR DOCTOR CANNOT BE REACHED

Physician's Signature _____ Date_____

Physician's Phone #'s _____

Physician's Stamp

Parent's Signature_____ Date_____

Parent's phone # H_____ C _____ W_____

EMERGENCY CONTACTS

1._____ Relation: _____ Phone: _____

2._____ Relation: _____ Phone: _____

3._____ Relation: _____ Phone: _____

Parents: Please label all Epipens with your child's name and date of birth

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Student Allergy Questions – Parents please complete

Name: _____ Date of Birth: _____ Grade: ____

1) What foods must your child avoid? (Please note which foods must NOT be ingested and which foods cannot be touched. Please distinguish between a food allergy and food intolerance)

2) Are there any regular supplies in a classroom that puts your child at risk?

3) Are there any extraordinary prior reactions that have happened that you would like us to know about?

4) What can we do to make your child feel more included in class activities, events and celebrations?

5) Is there anything else you would like the school to know about your child?