Palo Verde Head Start
295 E. Chanslorway
Blythe CA 92225
(760) 922-8454 Fax: (760) 922-3204

CARE PLANS

Program Year: _____

Teacher's Name: _____

Care Plan for:

Asthma: ☐ Epi-Pen: ☐ Food Allergy: ☐

Child's Name: _____ Date of Birth: _____

Parent/Guardian/Caregiver Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Physician Name: _____ Phone: _____

Medical Condition: ☐ Asthma ☐ Epi-Pen ☐ Food Allergy ☐ Other: _____

Asthma:

Medication to be given at SCHOOL: Start Date: _____ Stop Date: _____

1. Name: _____ Dosage: _____
   Frequency: _____ When to use: _____

   Can be repeated for severe breathing difficulty _____times _____minutes apart _____

Medication to be given at SCHOOL: Start Date: _____ Stop Date: _____

2. Name: _____ Dosage: _____
   Frequency: _____ When to use: _____

   Can be repeated for severe breathing difficulty _____times _____minutes apart _____

Epi-Pen: To be given at School

Anaphylaxis Triggers: (check all that apply)

☐ Animals ☐ Bee Sting ☐ Food ☐ Latex ☐ Other: _____

Warning Signs of an Anaphylactic Shock OR Asthma

☐ Diarrhea ☐ Lips appear blue ☐ Swelling of throat or mouth ☐ Difficulty breathing ☐ Severe nausea

☐ Vomiting ☐ Difficulty swallowing ☐ Sudden weakness ☐ Other:_____

What limitations are needed? (Restricted physical activity, dietary restrictions)_____

Use Epi-Pen:

1. Remove cap from EpiPen Carrying case and take out EpiPen
2. Grasp EpiPen as you would to stab wuth a knife
3. Remove safety release off off the pen with your opposite hand. Orange end has the needle
4. Firmly jab the EpiPen into the outer thigh at a perpendicular angle. Hold there for 3 seconds
5. Remove the pen from the thigh
6. Call 911. Tell the operator you have administered the EpiPen and to send emergency assistance
7. Place the used pen intp the safety case and take it with you to the hospital for proper disposal
8. Watch paitent carefully for recurring symptoms. If emergency assistance does not arrive in 15-20 mins, call 911 again

   EpiPen is made to go through clothing. Do not waste time removing clothing

Physician Signature: _____ Date: _____

I agree with the recommendations of my child's Physician as noted above.

Parent/Guardian/Caregiver Signature: _____Date: _____

California Department of Education
Nutrition Services Division

Child Nutrition Programs
CNP - 925 (Rev. 8/17)

MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School or Agency	2. Site Name	3. Site Phone Number
HEAD START	P.V.U.S.D	(760)-922-8454
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child or Participant's Physical or Mental Impairment Affected:

9. Explanation of DIET PRESCRIPTION AND/OR ACCOMMODATION to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child or Participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**