Procedures on Handling Suspected Cases of Food Poisoning at I-Shou University

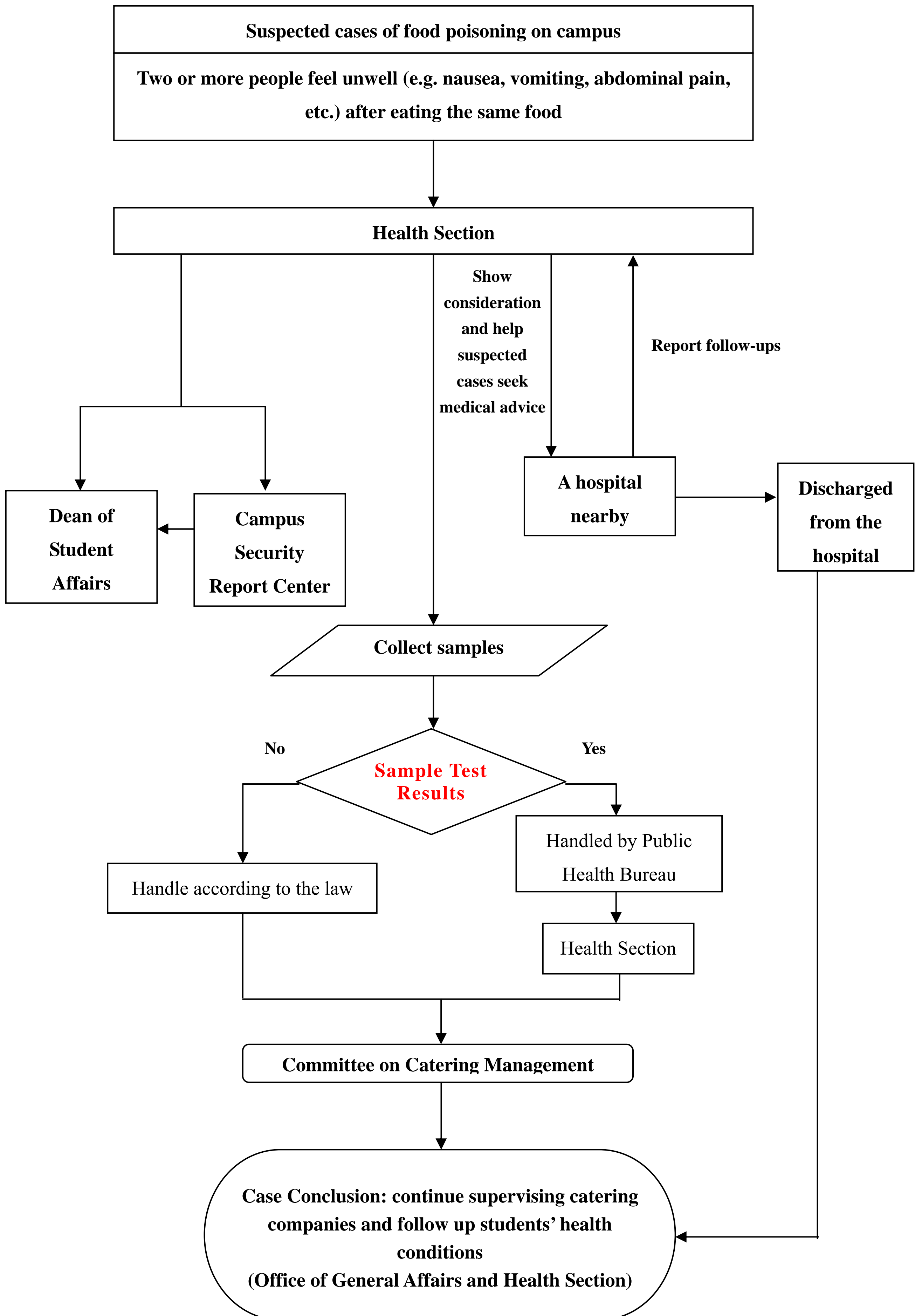

Table 1: Record Sheet of Suspected Cases of Campus Food Poisoning

Report Date	____ / ____ / ____ (y/m/d) ____ : ____ (h:m)
School	Name:___________________________ Contact No.: _______________ Fax No.:_______________ Address:
Possible Cause	Food possibly causing food poisoning: ______________________________ Food source or manufacturer: ________________________________
Food Sources	□ Homemade □ Business (restaurants or eateries) □ School Kitchen □ Boxed Lunch (or Catering Service) □ Convenience Store on Campus □ Others: ________________________________
Eating Time	____ / ____ / ____ (y/m/d) ____ : ____ (h:m)
Onset Time	____ / ____ / ____ (y/m/d) ____ : ____ ~ ____ : ____ (h:m)
Hospitalization	____ students and ____ teachers & staff have eaten the food ____ students and ____ teachers & staff are suspected of food poisoning ____ students and ____ teachers & staff have been sent to the hospital ____ students and ____ teachers & staff are still hospitalized
Symptoms	□ Nausea □ Vomiting □ Upper Abdominal Pain □ Lower Abdominal Pain □ Diarrhea □ Fever □ Sore Throat □ Allergy (□ Hot Flashes □ Itching □ Rash) □ Neurological Signs (□ Visual Disturbances □ Paralysis □ Vertigo) □ Others (please specify:____________________)
Medical Institutions	Name: (________ person-time) Hospitalized (________ person-time) Sent Home
Brief Description of Handling	

Fill in by: Unit Head: President:

Table 2: Hospitalization Record of Students Suspected of Food Poisoning

No.	Name	Student No.	Symptoms (please tick as appropriate and briefly descript)										Hospital	Arrival Time	Results		
			Nausea	Vomiting	Upper Abdominal Pain	Lower Abdominal Pain	Diarrhea	Fever	Sore Throat	Allergy	Neurological Signs	Others			Ward No.	Discharge Date	Note
1																	
2																	
3																	
4																	
5																	

Report Date: ____ / ____ / ____ (y/m/d) ____ : ____ (h:m)

Fill in by: **Contact No.:**