

Emergency Health Plan

For Allergy – Complete “Allergy Action Plan” Form

For Asthma – Complete “Asthma Action Plan” Form

Place
Child’s
Picture Here

Date: _____

Child’s Name: _____

Condition or Concern: _____

Please describe in detail any signs or symptoms for staff to look for:

ACTION PLAN:

If the signs or symptoms listed above appear staff should:

(PLEASE CHECK ALL THAT APPLY)

Give medication**

**** Any medication (prescription or over-the-counter) necessary for this plan must be accompanied by a Medication Authorization Form required by Office Of Child Care.**

Call Doctor (name) _____ (#) _____

Call 911

Call Emergency Contact #1 _____

Call Emergency Contact #2 _____

Other (describe in detail any other actions staff should take)

Family Member Signature: _____ Date: _____

Emergency Contacts	Trained Staff Members
1. _____ Ph. # _____	1. _____ Room # _____
2. _____ Ph. # _____	2. _____ Room # _____

Update: _____ Update: _____ Update: _____ Update: _____