EMERGENCY MEDICAL / ALLERGY ACTION PLAN

NAME_____ DATE of BIRTH_____

PARENT_____ PHONE_____

PARENT_____ PHONE_____

EMERGENCY CONTACT_____ PHONE_____

ALLERGY/MEDICAL CONCERN_____

_____

PHYSICIAN_____ PHONE_____

PRESCRIBED MEDICATION_____

Please describe symptoms, medication, and treatment plan: _____

_____

_____

_____

I,_____ (parent/guardian), agree to provide St. Thomas' teacher(s) with the necessary medication and/or Epi Pen needed for my child, _____. I agree to provide St. Thomas' Preschool with a current prescription for my child throughout the school year. I understand my child cannot attend St. Thomas' Preschool without the necessary prescription.

_____ _____

Parent's Signature Date

_____ _____

(Periodic Review) Parent Signature Date