Emergency Medical Treatment Plan

(To be updated annually or sooner if changes in treatment plan are necessary)

Parent Portion

Child's Name: _____ Birth date: _____
Physician: _____ Telephone #: _____
Parent Name(s) and Contact #s: _____
_____

I give permission for The Children's House to clarify physician's orders directly with my child's pediatrician, to post necessary info for staff to be made aware of the allergy/medical condition and to follow through on the treatment plan as described below.

Parent Signature: _____Date: _____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
MOUTH	Itching and Swelling of the lips, tongue, or mouth
THROAT	Itching and/or sensation of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNGS	Shortness of breath, repetitive coughing and/or wheezing
HEART	"Thready" pulse, "passing out"

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE –THREATENING SITUATION.

Physician's Portion

Allergy/Medical Condition: _____

For Allergic Reactions and Medical Condition Emergency Episodes: The staff should watch for the following symptoms *before* administering any treatment:

Please describe *at what point* the child will need treatment:

Treatment plan (please be specific):
(This form, once signed by physician, will serve as permission to administer all medications listed as part of the treatment plan.) ***Medical Personnel: No medical abbreviations please.***

Please note when/if 911 should be contacted. *****Please complete other side also***

Other Pertinent Information:

Instructions for Use of Epipen/Epipen, Jr.:

Instructions for use of Inhaler or Nebulizer:

Physician's Signature:_____ Date: _____

For Center Use:
Received by:

Original to child's folder – Copies to be placed in o/c classroom, attached to E-Card and in E-Book in Main Office