EMERGENCY MEDICAL CARE ACTION PLAN

This form must be completed by the client's Physician—PCP's please note that inhalers with spacers are preferred over nebulizers for ease of travel to the playground. This form must be updated annually from the date of the parent/legal guardian's signature.

Date: ___________

Client's Name: ____ D.O.B.: ____________________

This child requires emergency prescription medication for the treatment of:

- ☐ Allergies to: ____
- ☐ Asthma
- ☐ Other: ____

Part 1: Assessment

Symptoms of concern that should be closely monitored:

____

____

____

Symptoms indicating that immediate, on site, medical treatment is necessary:

____

____

____

Emergency attention at medical facility is necessary when:

____

____

____

Part 2: On Site Medical Treatment

Medication:
Dose/instructions:
Side effects:

3905 Ford Road, Suite 6, Philadelphia, PA 19131-2824
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Medication:
Dose/instructions:
Side effects:

Medication:
Dose:
Side effects:

Physician Signature: ___________________________ Date: _____________

Part 3: Emergency Plan

1. Call 911. State that: ____

2. Call Health Provider

Primary Healthcare Provider/Pediatrician:		Signature of Physician:	
Address:			
	Phone:	License Number:	Date Signed:

3. Emergency Contacts: **(completed by parent)**

Name	Relationship	Phone Number

Parent/Guardian Signature: ______________________________________ Date: _____________
You may return via fax attention to _______________________at 215-878-2082. Thank you for your prompt response.

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