Parent/Guardian:

Place Child's Picture Here

JEWISH COUNCIL FOR YOUTH SERVICES

Confidential Medical Emergency Action Plan

Student's name: _____ D.O.B: _____

This section to be completed by the physician.

Note: If multiple food allergies, can combine in one section if treatment plans are identical.

Use more than one form if there are more than three treatment plans.

ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure)

#1:

If allergy:

Life-threatening? Circle YES or NO **Contact or Ingestion? Circle CONTACT or INGESTION**

SYMPTOMS:

TREATMENT PLAN (including medication/dose/route):

If non-life-threatening allergy, check here _____ if 911 should not be called automatically.

ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure)

#2:

If allergy:

Life-threatening? Circle YES or NO **Contact or Ingestion? Circle CONTACT or INGESTION**

SYMPTOMS:

TREATMENT PLAN (including medication/dose/route):

If non-life-threatening allergy, check here _____ if 911 should not be called automatically.

ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure)

#3:

If allergy:

Life-threatening? Circle YES or NO **Contact or Ingestion? Circle CONTACT or INGESTION**

SYMPTOMS:

TREATMENT PLAN (including medication/dose/route):

If non-life-threatening allergy, check here _____ if 911 should not be called automatically.

Doctor's signature or stamp (required): _____ Date: _____

EMERGENCY CALLS (Note: this section to be filled out by parent/guardian)

Call 911 (unless contraindicated by physician in treatment plan) and state allergen/emergent condition and steps taken.

Call Dr. _____ at _____

Emergency contacts:

Name	Relationship	Phone Number #1	Alternate phone number

Parent/Guardian signature (required): _____ Date: _____