



# Medical Emergency Plan

## Food Allergies/Health Conditions

In accordance with CCL 746.605 (13) (16) this plan must be signed and dated by your child's health care professional.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Food Allergies/Medical Condition:**

\_\_\_\_\_

**Possible Symptoms if exposed to this food/medical alert arises:**

\_\_\_\_\_

\_\_\_\_\_

**Specific steps to take if the child has an allergic reaction or medical emergency:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If medications are part of the Medical Response. (Medication name/dose):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*\*Parent Signature

\_\_\_\_\_  
Date

\*\*With my signature, I give permission to Premier Prep School to post and carry out this plan as stated above.