EMERGENCY HEALTH CARE PLAN for CHILDREN with SPECIAL MEDICAL CONCERNS

Child's Name: ____ Date of Birth: _______________________________

****

The section below to be completed by child's doctor.

DOCTOR'S ORDER:

Name of Medication:____Prescription Number ___________________

Condition for which the medication is needed during school hours:

____

Doctor's requirements of dosage, time and method of administration:

____

Possible side effects: ____

What to do in case of side effects:____

****

Doctor's Signature: ____Date: __________________

Doctor's Name: ____

Doctor's Phone Number: ____

Doctor's Address:____

****

I hereby request that Peachtree Presbyterian Preschool assist my child in taking the medication herewith provided according to the instructions written above.

Parent's Signature: ____ Date _____________________