PLOWSHARES EDUCATION DEVELOPMENT CENTER, INC. 457 WALNUT STREET, NEWTONVILLE, MA. 02460
PH. 617-527-3755 / FAX 617-244-0227

ACTION PLAN FOR MEDICAL CONDITIONS

Child's Full Name_____ Date of Birth_____

Home Address_____ Zip Code_____

Medical Conditions_____

_____

(i.e. Food-ingestion and/or exposure, Bee stings, Asthma etc.)

Symptoms of an allergic reaction may include: (check all that apply)

_____Trouble breathing	_____Wheezing/Cough	_____Dizziness	_____Vomiting	_____Skin Rash/Redness
_____Throat tightening	_____Swelling	_____Fainting	_____Eye Puffiness	_____Nausea
_____Diarrhea	_____Abdominal Pain	_____Hives	_____Itchiness	_____Sneezing

Symptoms/Asthma reactions:

_____Wheezing _____Coughing _____Tight Chest _____Breathing hard and fast _____Nostrils flaring _____Trouble Talking

OTHER:_____

_____

EMERGENCY ACTION (if necessary):_____

_____

TREATMENT: To be administered at Plowshares **(Please be specific and detailed)**

Name of Medicine(s)_____Dosage_____

_____Dosage_____

When to Administer_____

_____

****Side Effects of Treatment**_____

****Consequences of Non-Treatment**_____

I give _____my permission to instruct the staff of Plowshares Child Care in the specifics
(PARENT/GUARDIAN(S) NAME)
regarding his/her child's_____ medical/health condition treatment and the side effects of
(CHILD'S NAME)
that treatment.

Physician Name (**print**)_____ Tel#_____

Signature _____ Date_____

Allergist Name (**print**)_____ Tel#_____

Signature _____ Date_____

-OVER-

Additional Information / Instructions:

_____

_____

Call Parent(s) / Guardian(s) with any questions or concerns.

Parent/Guardian__**_____Relation _____**

HOME TEL#_____WORK #_____CELL#_____

Parent/Guardian__**_____ Relation_____**

HOME TEL#_____WORK #_____CELL#_____

Signature _____Date_____
Parent/Guardian

Signature _____Date_____
Parent/Guardian

ALL PLOWSHARES EDUCATORS WHO ARE TRAINED BY CPR SERVICES AND HAVE COMPLETED EEC'S 5 RIGHTS MEDICATION ADMINISTRATION TRAINING MAY ADMINISTER MEDICATION TO MY CHILD.

Child's plan was created by_____ Date_____

Child's plan is maintained by_____Date_____

_____Date_____