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Medical Action Plan

For Asthma, Food Allergies and Other Medical Concerns

Child's Name _____ Date of Birth _____

SPECIFIC MEDICAL CONCERN:

Prescribed Medications: _____

Doctor's Name: _____ Phone: _____

Signs or Symptoms: _____

Action to be taken if any of these signs or symptoms: _____

Contact the parent if: _____

Seek emergency medical care if the child has any of the following: _____

Parent/Guardian Name: _____ Ph (H) _____ Ph (W) _____

Parent/Guardian Name: _____ Ph (H) _____ Ph (W) _____

Emergency Contact Name: _____ Ph (H) _____ Ph (W) _____

Emergency Contact Name: _____ Ph (H) _____ Ph (W) _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Physician's Signature _____ Date: _____