Medication, Allergy, and Asthma plan of action.

Child's name_____ DOB_____

Physicians name _____ Phone number:_____

Storage: All Medication will be stored in the front office. Room temp storage will be kept in the top drawer of the filing cabinet. For Cold storage, the medication will be kept in the Staff Fridge in the kitchen.

Medication consent form attached ☐

This plan is to monitor:_____ **Medication**:_____

Mild symptoms include:

Plan of action for Mild symptoms including administration of medication:

Sever Symptoms include:

Plan of action for Sever symptoms including administration of medication:

Communication:

Staff will follow the plan of action as needed. Next we will contact the guardians as soon as possible to communicate the symptoms and actions taken. A discussion will conclude next steps if the child is well enough for school or if they need to be picked up. If symptoms are sever we will follow the plan of action and then call the emergency number as needed.

Parent Signature:_____ As the parent or guardian I have gone over a plan of action with my Physician to creat a plan of action that will be in the best interest of my child for a child care setting. I will keep medications and contact information up to date.