Temple Beth Shalom Children's Center
Health Care & Allergy Action Plan

Attach recent photo of child here.

Child's Name: _____

Description of chronic condition: _____

Treatment & Notification

Symptoms: _____

Action to be taken:

1. _____
2. _____
3. _____

Parent contact: Name _____ Phone _____

If parent cannot be reached, call emergency contact:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Potential side effects of treatment: _____

Potential consequences if the treatment is not administered: _____

Notes:

I authorize the above action plan. I authorize Temple Beth Shalom to train educators to address this medical condition.

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date _____

I consent to the above plan and give permission for this information to be posted in my child's classroom.

Parent signature _____ Date _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin**)_____

My child has previously taken this medication_____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____ **Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin **(parent signature only)**