PLAN OF ACTION for EMERGENCY MEDICATION

Child's Name: _____

OFFICE USE ONLY
Form expiration date: _____
(6 months)

(1) Medication name: _____ Dosage: _____

(2) Medication name: _____ Dosage: _____

(3) Medication name: _____ Dosage: _____

Symptoms that indicate the need for the emergency medication:

Actions to take once symptoms occur:

Instructions and method of administration:

I, the undersigned, give permission for the medication-trained staff of Young Years to give the above medication(s) as prescribed and described to my child. I release Young Years of all liability, provided the above instructions have been observed.

Parent's Signature: _____ Date: _____