Medical Action Plan for Wake Forest Baptist Church

Child's Name: _____ Age: _____

Date of Birth: _____ Class: _____

Allergy to/Medical concern: _____

_____

Treatments/Medications Required: _____

_____

Symptoms/Treatments: In this area, please be specific as to the symptoms we need to look for and specific instructions you would like for us to follow in the event of a medical emergency involving your child's medical concern listed above:

In the Event of an Emergency with this child,

1. **Call 911**. Give the operator the information of an allergic reaction and request an ambulance. Church address: 107 E. South Avenue, Wake Forest, NC 27587— Ph.#: 556-5141(church).

2. Parent_____ Phone #: _____

3. Emergency Contacts:
   Name/Relationship Phone Numbers:

a. _____ _____

b. _____ _____

IF ADVISED BY MEDICAL PERSONNEL, CHILD WILL BE TRANSPORTED TO HOSPITAL:

HOSPITAL OF CHOICE: _____
(Hospital's name)

Parent/Guardian's Signature: _____ Date:_____