



NAVY CYP EMERGENCY ACTION PLAN

CHILD'S INFORMATION		
Child's Name	DOB	Place Child's Photo Here
Parent/Guardian Name	Home Phone	
Parent/Guardian Name	Cell Phone	
Emergency Phone Contact #1 Name	Contact #1 Phone	Contact #1 Additional Phone
Emergency Phone Contact #2 Name	Contact #2 Phone	Contact #2 Additional Phone

CHILD'S NEEDS (please describe)		
Allergies	Asthma	Other



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DAILY MEDICATION PLAN		
Name	Amount	When to Use
Name	Amount	When to Use
Name	Amount	When to Use
Name	Amount	When to Use

CHILD AND YOUTH PROGRAM ENVIRONMENT (Environmental control measures, special precautions and/or dietary restrictions)

IRRITANTS (Check all that apply)									
Animals	<input type="checkbox"/>	Bee/insect sting	<input type="checkbox"/>	Chalk	<input type="checkbox"/>	Molds	<input type="checkbox"/>	List Other:	
Dust mites	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Dust	<input type="checkbox"/>	Strong odors	<input type="checkbox"/>		
Food	<input type="checkbox"/>	Respiratory infection	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Other	<input type="checkbox"/>		
Pollens	<input type="checkbox"/>	Change in temperature	<input type="checkbox"/>	Smoke	<input type="checkbox"/>				



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EMERGENCY ACTION PLAN

1. Emergency action is necessary when the child has any one of the following symptoms:

2. Action:

3. Action:

4. Contact Parent/Guardian:

5. **Call 9-1-1** if the child has any one of the following symptoms:

SPECIAL INSTRUCTIONS

Please provide any additional instructions and/or guidance for CYP Professionals:

PHYSICIAN INFORMATION

Physician Name (Printed/Stamped)

Contact Information

Physician Signature

Date Completed