

Insert Child’s Photo

PLEASE PRINT CLEARLY

**Medical Condition Action Plan**

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| Child’s name: |
| Date of birth | Year level 3yo 4 yo  |
| Details of the diagnosed health care need or medical condition including the severity of the condition: |
| Please detail any current medication prescribed for the child: |
| Please detail the response required from the service in relation to the emergence of symptoms: |
| Medication required to be administered in an emergency:Name of medication: Dose:  |
| The response required if the child does not respond to initial treatment: |
| When to call ambulance: |
| Does the child usually tell an adult if he/she is feeling unwell? Yes No |

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| **Parent/Guardian**I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of nay emergency medical costs.Signature: Date: .Name: . |

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| **Emergency contact information**:Contact name .Phone: Home Mobile: .  |

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| **Doctor**Name of doctor .Address .Phone .Signature Date . |