Action plan for MEDICAL CONDITION

CHILD'S NAME: _____

DATE OF BIRTH: / / YEAR: ROOM: DATE: / /20

PHOTO	**DESCRIPTION OF MEDICAL CONDITION**
	SIGNS & SYMPTOMS
	Signs (What is seen)
PARENT/CARER NAME/S	•
•	•
•	•
HOME PHONE:	
	Symptoms (What the child feels)
WORK PHONE:	•
MOBILE PHONE:	•
PLAN PREPARED BY	•
Dr:	**ACTION**
Signed:	**1.**
Date:	**2.**
AMBULANCE COVER	**3.**
YES / NO	**4.**
PARENT SIGNATURE	**5.**
DATE: / /20	**ADDITIONAL INFORMATION**
If medication is to be given, separate forms for Parent ☐ and Doctor to be completed ☐	
MEDICATION FORMS	
Signed by Doctor: ☐	
Signed by Parent: ☐	
MEDICATION SUPPLY	
Parent to supply medication. Medication kept:	

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