Dianella Heights Primary School
Independent Public School

Action Plan for Medical Condition

Child's Name:

Date of Birth: ..... / .... / .... Year: .... Room: .... Date:.........../.............../20 ....

PHOTO	DESCRIPTION OF MEDICAL CONDITION
	SIGNS & SYMPTOMS
PARENT/CAREER NAME'S	Signs (What is seen)
Hm Tel:	
Wk Tel:	Symptoms (What the child feels)
Mobile:	
PLAN PREPARED BY	
Dr:	
Signed:	ACTION
Date:	
AMBULANCE COVER	
YES / NO	
PARENT SIGNATURE	
Date: / / 20	
If medication is to be given seperate forms for Parent ☐ and doctor ☐ to be completed	ADDITIONAL INFORMATION
MEDICATION FORMS	
Signed by Doctor ☐	
Signed by Parent ☐	
MEDICATION SUPPLY	
Parent to supply medication ☐	