



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 <input type="checkbox"/> and doctor <input type="checkbox"/> to be completed	ADDITIONAL INFORMATION
MEDICATION FORMS	
Signed by Doctor <input type="checkbox"/>	ADDITIONAL INFORMATION
Signed by Parent <input type="checkbox"/>	
MEDICATION SUPPLY	
Parent to supply medication <input type="checkbox"/>	

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