



MEDICAL ACTION PLAN 2021

Student's Full Name: _____

Address _____

Date of Birth: _____ Class: _____

1. Illness or Medical Condition: _____

2. Triggers of Condition: _____

3. Medication (please state name in full) : _____

4. Timing of administering medication:

Given at intervals specified by the doctor on the medication.

To be taken by student when the following symptoms occur:

Actions Required: _____

5. Symptoms that indicate emergency medical intervention is necessary: _____

In the event of a medical emergency, and where a parent cannot be contacted, I authorise the dance school to call an ambulance or seek medical advice for my child at a hospital at the parent's expense.

6. Contact phone numbers to call:

Home phone number: _____

Mobile phone number: _____

Other numbers: _____

Doctor's Name: _____

Doctors Number _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____