MEDICAL ACTION PLAN 2019

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: _____

Dorctors Number _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____