ATTACHMENT 4

Medical Condition Medical Plan

Date ________________________________

Child's Name ____ Age ____

Parents Contact Number (H) _______________ (B) ________________ (M) ___________________

Emergency Contact Person: Name ____________________________ Phone________________

Doctor: ______________________________________ Doctor Phone: ________________________

Medical Condition | **Common Signs & Symptoms Condition**

___________________________________ | ___________________________________

___________________________________ | ___________________________________

___________________________________ | ___________________________________

Regular Medication

Medication	Dose	Time(s)	How given

Emergency Treatment Action Plan

1. ____
2. ____

I (doctor's name) ____________________ endorse the above treatment as appropriate for this child.

Doctor's Signature: ____Date: _________

I ____ (parent's name) hereby authorise Staff of the Shine Bright EYM to obtain such urgent medical assistance and treatment for my child in the case of an episode.

Parent's Signature: _______________________________________ Date: _____________________

NB You may need to consult your doctor when filling in this information sheet.
This plan enables staff to follow guidelines set out by the child's parent and/or according to their doctor.