ATTACHMENT 4



**Medical Condition Medical Plan**

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| 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** | | | | | | | | |
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| **Regular Medication** | | | | | | | |  | | |  | |  | | | | |  | |
| Medication | | | | | | | | Dose | | | Times | | How Given | | | | | | |
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| **Emergency Treatment Action Plan** | | | | | | | | | | | | | | | | | | | |
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| I |  | | | | | | (doctor’s name) endorse the above treatment as appropriate for this child. | | | | | | | | | | | | |
| Doctor’s Signature: | | | | | |  | | | | | | | | | | Date: | |  | |
|  |  | | | | | |  | | | | | | | | | | | | |
| I |  | | | | | | 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. | | | | | | | | | | | | | | | | | | | |

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