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** |
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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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