Medical Action Plan 2025

(Please attach Medical Action Plan from Medical Practitioner)

Student's name: _____

Current class and teacher: _____

Medical Condition: _____

Triggers: _____

If your child is on any medication, please provide name, dose and time taken:

_____

Medication provided to school, dose and time to be given:

_____

Where medication is kept at school: _____

Relevant history (e.g. asthma attacks, anaphylaxis etc.):

_____

_____

Symptoms:

_____

_____

Indicators for the need for medical intervention:

_____

Emergency Procedure:

_____

_____

Parent/Guardian names and phone numbers:

_____

_____

Signature of parent/guardian: _____ **Date:** _____