

# Medical Plan



**Centenary Drive Kindergarten**

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ABN : 85 613 569 498

Reg No : A0019473G

Childs Name : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Age : \_\_\_\_\_ Kindergarten Group : \_\_\_\_\_

Parent/Guardian's Names : \_\_\_\_\_

Phone : (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Emergency Contact Name : \_\_\_\_\_ Phone : (H) \_\_\_\_\_ (M) \_\_\_\_\_

Doctor's Name : \_\_\_\_\_ Phone : \_\_\_\_\_

**Action Plan** : This section is to be completed by the child's Doctor in consultation with the parent/guardian.

**What is the medical reason for this plan?** Allergies / Diabetes / Epilepsy / Other ( Please describe)

**Describe the child's usual reactions, signs or symptoms.**

**Describe any known triggers.**

**What is Medical Action Plan?** (List medications, dosages, administration procedures, time intervals and contact numbers)

**Additional relevant information** (eg. medication side effects)

Parent/Guardian Name : \_\_\_\_\_

Parent/Guardian Signature : \_\_\_\_\_

Date : \_\_\_\_\_

Doctor's Name : \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Date : \_\_\_\_\_