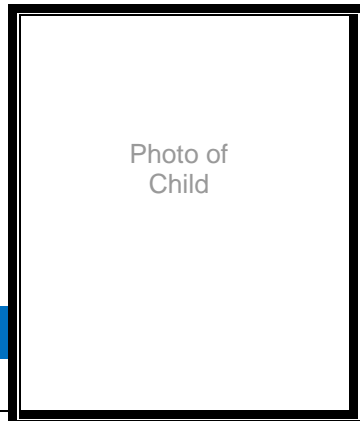




-MEDIC ALERT- ACTION PLAN



This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers must inform the school/service immediately if there are any changes to the management plan. Please tick (✓) the appropriate box, and print your answers clearly in the blank spaces where indicated.

PERSONAL DETAILS

Child's name: _____ Male Female
(Surname) (First Name)

Date of birth: / / Year/Group: Teacher/Educator:

EMERGENCY CONTACT (e.g. parent, carer):

(a) Name: _____ Relationship: _____
Telephone No _____ Alternative No _____
(b) Name: _____ Relationship: _____
Telephone No _____ Alternative No _____
Doctor: _____ Telephone No: _____

USUAL ALLERGY MANAGEMENT PLAN

Child's symptoms (e.g. rash, cough):	Triggers (e.g. exercise, pollens):

MEDICATION REQUIREMENTS:

Name of medication: _____
When and how much? _____
Method: _____

IN AN EMERGENCY FOLLOW THE ACTION PLAN BELOW:

Blank space for emergency action plan instructions.

Additional comments:

Blank space for additional comments.

I authorise service staff to follow the Emergency Plan. I will notify you in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has allergy symptoms at school/service.
I verify that I have read the Medic Alert Action Plan and agree with its implementation.

Name of Parent/Guardian: PLEASE PRINT	Signature: _____	Date: / /
Name of Doctor: PLEASE PRINT	Signature: _____	Date: / /
Name of Authorised Line Manager: PLEASE PRINT	Signature: _____	Date: / /