-MEDIC ALERT-

ACTION PLAN

Photo of Child

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:

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: / /