LABURNUM PRIMARY SCHOOL

OUR VISION
Learn • Thrive • Contribute

OUR VALUES
Curiosity • Respect • Integrity • Resilience

MEDICAL CONDITION MANAGEMENT PLAN

Photo of your child must be attached

This form should be completed in consultation with the family doctor if necessary.

STUDENT'S NAME: .....

DATE OF BIRTH: .....**AGE:** .....

Please tick if your child is living with any of the following health conditions:

☐ Asthma (if ticked an Asthma Action Plan is required, completed by doctor)

☐ Anaphylaxis (if ticked an Anaphylaxis Action Plan is required, completed by doctor)

☐ Allergy (if ticked an Allergy Action Plan is required, completed by doctor)

☐ Heart condition ☐ Diabetes ☐ Epilepsy ☐ Migraine/Headache

☐ Anxiety/Depression ☐ Cancer ☐ Cystic Fibrosis ☐ Blood Disorders

☐ Other:_____

_____

KNOWN ALLERGIES: ☐ Anaphylaxis (EpiPen Required) ☐ Allergy

Anaphylactic to the following items: _____

Allergic to the following items:_____

DETAILS.....

.....

.....

(Please turn over)

CONDITION AND DESCRIPTION:

(included symptoms)

………

………

………

SYMPTOMS OF DETERIORATION:

(included the time frame and known usual course of the reaction)

………

………

………

USUAL MEDICAL TREATMENT REQUIRED AT SCHOOL OR DURING ACTIVITIES:

……..

……..

,,

MEDICAL TREATMENT AND ACTION NEEDED IF CONDITION DETERIORATES:

……

……

……

DECLARATION:

I agree to my son/daughter receiving the treatment described above, I also agree to pay all expenses incurred for any treatment deemed necessary.

PARENTS/GUARDIANS: …………………………………………………………………………………… DATE: …………………………….

…………………………………………………………………………………… DATE: …………………………….

DOCTOR'S COMMENT'S: (if appropriate)

……..

……

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DOCTOR SIGNATURE: ………………………………………………………………………………… DATE……………………………….

- If at all possible, medication should be taken at home.
- Please included a core comprehensive management plan if you wish.