FORM 7 – Medical action plan

MEDICAL ACTION PLAN

Student's Full Name: _____

Date of Birth: _____ Class: _____

1. Illness or Medical Condition: _____

2. Triggers of Condition: _____

_____

3. Medication *(please state name in full)*: _____

4. Location of medication on College Campus *(please tick the following options):*

Secondary Reception

Primary Reception

Classroom (primary only)

All medication in the options above is kept in a secure cupboard and is administered by an authorised staff member of the College.

OR for non-schedule medication:

☐ On student's person or school bag during school day

☐ To be taken with student on excursions/sport days/camps.

5. Timing of administering medication:

☐ Given at intervals specified by the doctor on the medication.

☐ To be taken by student when the following symptoms occur:

_____

_____

☐ Other:

_____

_____

6. Symptoms that indicate emergency medical intervention is necessary:

_____

_____

7. Contact phone numbers to call:

Home phone number: _____

Mobile phone number: _____

Other numbers: _____

Doctor's Name: _____

Doctor's Signature: _____

Date: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____