Springfield Bees
PRE-SCHOOL

Child Health Care Plan

This management plan must be completed together with the parent/guardian and if necessary, medical practitioner. One copy should be kept in the child's personal file and another with their medication (if required) in their room

Attach child's photo here

Name:

Date of birth:

Medical need/allergy:

Date when setting insurance company notified:

A record must be kept in the child's personal file of any first aid or administration of medication.

Emergency First Contact

Name of Parent/Guardian

Address

Home Phone

Work Phone

Emergency Second Contact

Name

Address

Home Phone

Work Phone

Emergency Third Contact

Name

Address

Home Phone

Work Phone

GP Contact Details

Name

Address

Phone Number

Medical Specialist Details

Name

Address

Phone Number

Signs and symptoms of allergy or medical need:

Care Plan:
(To include details of risks, procedures, medication and emergency procedures after consultation with parents/guardians and medical practitioners. Include a list of prescribed medication).

Emergency Action Plan:

Key staff who have under gone training:

Name

Date trained

Name

Date trained

Name

Date trained

Name

Date trained

Parent/Guardian consent:

I hereby give consent for the trained staff to administer medication and or first aid.
I hereby give consent for staff to seek help from accident & emergency services and or a medical practitioner.

Signed **Date**

Print name

Signed **Date**

Print name