

# Medical Management Action Plan

Photo

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Emergency Contact Persons

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact No: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact No: \_\_\_\_\_

Treating Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

## Diagnosis and Risk Minimisation

**Medical Diagnosis / Health Care Need:**

**Known Triggers / Risks:**

**Medical / Behaviour Support:**

**Special Considerations**

## Medications

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time Given/ Frequency: \_\_\_\_\_

## Management Action Plan

Signed by Parent: \_\_\_\_\_ Date: \_\_\_\_\_

