Medical Management Plan

Insert Photo of Child

Child's Name _____

Date of birth _____

Plan Date _____ Review date _____

Medical condition or allergy information (including triggers)

_____
_____
_____
_____
_____
_____

First Aid/Medication Required

_____
_____
_____
_____
_____
_____

Doctor

Name of doctor _____

Address _____

Phone _____

Signature _____ Date _____

Parent

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions.

Signature _____ Date _____

Name _____