PERSONAL MEDICAL ACTION PLAN

Photo of student

(Will be arranged by CMS)

Name:

Room:

Medical Condition:

Medication & Dosage to be issued:

Treatment required (Please describe below or continue over the page if necessary):

e.g. My child reacts to bee stings by severe swelling to the area. Has been to the Doctor for treatment but never hospitalised. Medication is 2 antihistamine tablets immediately. Get to a Doctor if the swelling does not go down.

Any known Allergies (include what allergy, symptoms of reaction and severity):

Parent/Caregiver name and address:

Phone:

IN AN EMERGENCY, IF WE CANNOT CONTACT YOU, WHO IS THE NEXT PORT OF CALL?

NAME:

RELATIONSHIP TO CHILD:

ADDRESS:

PHONE:

Family Doctor Name: **Doctor Phone:**

I give permission for the medication described above to be administered if and when necessary by the staff of Cambridge Middle School. If my child requires short or long term medication i.e., cough syrup/antibiotics, I will send/preferably bring, a note to school which will give the staff of Cambridge Middle School permission to administer the medication. **NO medication will be given unless it has a pharmaceutical label with the child's name, clear dosages, the name of the drug, expiry date (if applicable) and where it is to be stored i.e. fridge.** In the event of an accident or sudden illness, I authorise the staff of Cambridge Middle School to obtain medical emergency assistance as necessary. Although all due care will be taken by CMS staff, the school is relying on accurate and up to date information if we are to assist in an emergency situation.

Parent/Caregiver Digital Signature:

Date:

NB: This Authority requires to be renewed yearly or will end at the completion of the course of medication being issued.