

# REGISTER OF MEDICAL CONDITION



***If your child has a condition which you consider warrants your child being on our Special Needs Register, please fill out the form below and return it to the School Office immediately.***

Student's Name \_\_\_\_\_

Class \_\_\_\_\_

Diabetes  Epilepsy  Asthma  A.D.D.

Allergy  i.e. bee stings (please indicate severity)

Allergy  to certain foods/medications (please list on the back of this form which foods/medications)

Other

Name of Doctor diagnosing medical condition: Dr \_\_\_\_\_

Date of last visit to Doctor \_\_\_\_\_

Is your child on regular medication? Yes   
No

In an emergency, when parents cannot be contacted:

- Permission is given for a child to be transported by ambulance to hospital
- Permission is given for a child to be taken to the nearest Doctor

It is the parent's responsibility to keep parent contact information up-to-date.

**Ambulance costs to be met by parents.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# EMERGENCY ACTION PLAN



***If your child has any condition which may require an Emergency Action Plan please fill in the Plan below so that staff members are aware of exactly what to do, in what order, in the event of an medical emergency of your child.***

Student's name: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Symptoms that may be observed: \_\_\_\_\_

\_\_\_\_\_

Treatment to be administered by staff: \_\_\_\_\_

\_\_\_\_\_

Medical Practitioner to be contacted: Dr \_\_\_\_\_ Phone No: \_\_\_\_\_

Proximity to the school: \_\_\_\_\_

Transportation arrangements: \_\_\_\_\_

Further Information:

Emergency Action Plan to be revised: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_