

# Somerset Primary School

## Medical Action Plan

Somerset

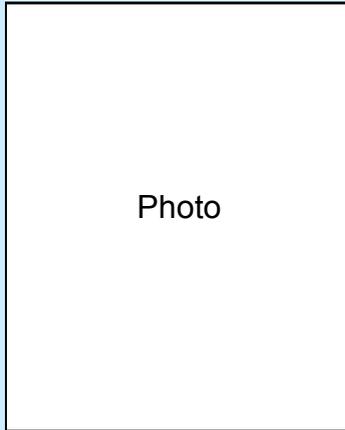


PRIMARY  
SCHOOL

*Our future starts here*

Name:

Date of Birth:



Photo

### Emergency Contact Details

Name:

Relation to child:

Mobile Phone:

Home Phone:

Work Phone:

In the event of an emergency, I authorise the First Aid person in charge to follow this action plan. Should any of the attached details change at any time, I undertake to immediately notify the school A.S.A.P.

Signed:

Date:

### Predetermined Other Medical Condition(s)

My child suffers from the following medical condition(s) (please specify):

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Or alternatively, my child has an allergy to:

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### Warning Signs and Symptoms (Please tick if applicable)

- Swelling (eyes, lips, face, tongue)
- Difficulty breathing
- Coughing
- Hives or welts
- Tingling mouth
- Abdominal pains, vomiting (signs of severe reaction to insects)
- Cold, clammy skin
- Stomach cramps, diarrhoea
- Flushed face/body
- Difficulty talking and/or hoarse voice
- Fainting
- Persistent dizziness or collapse
- Other:

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### ACTIONS TO TAKE

1.

2.

3.

4.

5.