Somerset Primary School
Medical Action Plan

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):

_____

_____

Or alternatively, my child has an allergy to:

_____

_____

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:

_____

ACTIONS TO TAKE
1.
2.
3.
4.
5.