|  |  |
| --- | --- |
| **Medical Condition:** |  |
| **Description of medical condition: (Triggers- if applicable, preventative actions)**  |  |
| **Signs and Symptoms**  |  |

|  |  |
| --- | --- |
| **Actions to manage the medical condition/ presenting symptoms**  | **Medication** |
| ***Name*** | ***Frequency*** | ***Dose*** | ***Method*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| ***Possible side effects of medication:***  |

|  |  |
| --- | --- |
| **First Aid / Emergency Treatment** | **Phone 000 for an ambulance**  |

|  |  |
| --- | --- |
| **Comments** |  |

|  |  |
| --- | --- |
| **Emergency contact name:** |  |
| **Phone:** |  |

|  |  |
| --- | --- |
| **Doctor / specialist name:** |  |
| **Phone:** |  | **Date**\***:**  |  | **Signature:** |  |

\*This Medical Management Plan must be reviewed when medical needs change or every 18 months.