

Matthew Gibney Catholic Primary School

EMERGENCY ACTION PLAN

Student's Name: **Class:**

Date of Birth:

Medical Condition:

.....
.....

**Medication must be supplied
to the office.**

Expiry Date

Symptoms that may be observed:

.....
.....
.....
.....

Emergency Action:

- (1)
- (2)
- (3)

Has your child's Medical Practitioner provided a health care plan to assist the school to manage the condition? YES / NO (If 'YES' please advise the Principal / Office).

Medical Practitioner to be contacted: Dr Phone

In the event of an emergency I give permission for my child to be transported by ambulance/taxi to obtain medical attention. **YES / NO**

Caregiver's Name

Caregiver's Signature

Caregiver's Mobile Date