Personal Medical Action Plan

MORRINSVILLE
Intermediate School
Kia U Ki Te Pai Whatever You Do, Let It Be Your Best

Student Name:

Room:

Medical Condition:

Medication and Dosage Required:

Treatment Required: (Please describe below e.g. child requires 2 - 5 puffs of Symbicort through a space, please contact parents if needed.)

Any known allergies or dietary requirements: Include what the allergy is as well as the symptoms of a reaction and its severity. This information will also be passed onto our Food Tech Department.

Consent:

- I give permission for the medication described above to be administered if and when necessary by the staff of Morrinsville Intermediate School.
- If my child requires short term medication (e.g, antibiotics) I will complete a Medicine Authority Form (downloaded from the school website) which will be given to the office staff of Morrinsville Intermediate School giving them permission to administer the medication.
- We recommend medication has a pharmaceutical label with the child's name, clear dosages, the name of the drug, expiry date (if applicable) and where it is to be stored i.e. fridge.
- In the event of an accident or sudden illness, I authorise the staff of Morrinsville Intermediate School to obtain medical emergency assistance as necessary. Although all due care will be taken by MIS staff, the school is relying on accurate and up to date information if we are to assist in an emergency situation.

Family Doctor Name:

Doctor Phone Number:

Parent/Caregiver Digital Signature:

Date:

NB: This medical action plan must be reviewed regularly and updated as required.

Extra Notes: