Early Childhood Management Services

2.12.3

Operations

# Medical Management Plan

This plan will be developed by the child's medical practitioner and reviewed each 12 months.

| Name of Child: | | Insert photo here |
|---|---|---|
| Date of Birth: | | |
| Parent Name: | Dr Name: | |
| Parent Address: | Dr Phone: | |
| Parent Number: | | Mobile: |

| Medical Condition |
|---|
| |
| **Symptoms & causes** |
| |
| **Action and treatment, including medication administration details** |
| |

This authorisation is valid from to or until any changes to the medical management plan are made.

**Medical Practitioner Name**

Print Name: _____

Signature: _____ Date: _____