|  |  |
| --- | --- |
| **Care Plan** | |
| Childs Name: | Date of birth: |
| Medical Condition: | |
| Treatment Required: | |
| Emergency Contact 1:  *Name, Relationship, Contact Number* | |
| Emergency Contact 2:  *Name, Relationship, Contact Number* | |
| Name of Medication: | |
| Amount of Medication/Feed: | |
| Equipment: | |
| Risk Assessment:  *Completed Date / Signature* | |
| **Procedure** | |
| **In the event of**  *(insert emergency)* | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Professional**  Signed | Name |  | Date |  |
| **Parent**  Signed | Name |  | Date |  |