|  |
| --- |
| **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 |  |