**Health Care Plan**

*To be completed by the parent/carer and returned to the club ASAP.*

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| **Name of Child:**  INSERT PHOTO HERE  **Date of Birth:**  **Doctors Name, Address, Contact Number:** |
| **Allergy/Intolerance/ Dietary requirement/Medical Condition:** |
| **How to support me/Emergency procedure to follow:** (provide as much detail as possible) |
| **Medicine required in an emergency** (please include name, dosage, expiry date – medicine must be provided, we can only give medicine if it has a prescription label and) |
| **Emergency Contact 1:** (Name and telephone number)  **Emergency Contact 2:** |
| **Parent Signature:**  **Creation Date:**  **Manager Signature:**  **Review Date:** |

**Medicine Administration Form**

**Child’s name** …………………………………………………………………………………………………………………………

**Reason for medication** ……………………………………………………………………………………………………

**Name of medication** …………………………………………………………………………………………………………….

**Dosage and method of administration** ………………………………………………………………………………

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**Date Medication Expires** ……………………………………………………………………………………………………

**How to store medication** …………………………………………………………………………………………………….

**Signature of Parent/Carer** …………………………………………………. **Date** …………………………………

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| **Date** | **Dosage & staff signature** | **Parent/Carer signature** |
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