Child Long Term Medication & Chronic Illness Health Record

Child's Name | Date of Birth | Gender

Other

Which condition does your child have?

(PLEASE USE BLANK SPACES FOR ADDITIONAL SIGNS)

- ☐ ALLERGY
- ☐ ANAEMIA
- ☐ ASTHMA
- ☐ ECZEMA
- ☐ HEARING PROBLEMS
- ☐ DIABETES
- ☐ HEART PROBLEMS
- ☐ KIDNEY DISEASE
- ☐ EPILEPSY

What happens to your child when s/he has a crisis related to this condition?

Action Plan 1

Action Plan 2

Action Plan 3

Medication required for this condition?

Dose | Frequency

EMERGENCY CONTACT (OTHER THAN PARENT)

Name | Contact | Email

Relationship to Child | Child's Doctor | Contact

Parent's Name | Contact | Email

Date

THIS FORM WILL BE KEPT IN THE CHILD'S FILE AND THE STAFF OF CENTRE WILL BE MADE AWARE OF THE INFORMATION. IT WILL BE CHECKED BEFORE ACTION IS TAKEN.