MEDICAL MANAGEMENT PLAN

Child's First Name & Surname: ______________________________

Child's Date of Birth: ________/__________/______________________

Child's Medical Condition:

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Action to be taken in the event of symptoms being evident:

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Child's Doctor: ____

Child's Doctor's Address & Phone Number: ______________________

Parent Name: ____

Parent / Guardian Signature: _________________________________

Parent Phone Number: _______________________________________

PLEASE COMPLETE & UPLOAD TO YOUR TEAMKIDS ACCOUNT.