



## 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.