Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:

__ Parent
X Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)
__ Other: ___________________________

Plan is maintained by:

X Director
X Assistant Director
__ Child's Educator
__ Other: ___________________________

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition: **Group leaders & administrators who have taken 5 rights of medication training**
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant): **Child's parent and first aid instructor**

Name of Licensed Health Care Practitioner (please print):____

Licensed Health Care Practitioner authorization:________________________________ Date:___________

Parental/Guardian consent: ____ Date:___________

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _______________ Date of birth: _____________________ Back-up medication received? YES NO

Parent signature: ____ Date: ________________________________

Administrator's signature: ____ Date: ________________________________