

**Individual Health Care Plan Form**  
Plan must be renewed annually or when child's condition changes

Child's Photo

Check all that apply....

**Plan was created by:**

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

**Plan is maintained by:**

Director \_\_\_\_\_  
Assistant Director \_\_\_\_\_  
Child's Educator \_\_\_\_\_  
Other: \_\_\_\_\_

Name of Child:	Date:
Any change to the child's Health Care Plan? <b>YES</b> (indicate changes below) <b>NO</b> (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:	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

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: \_\_\_\_\_