

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

Any change to the child's Heath Care Plan? YES (indicate changes below) NO (updated physician/parental signatures required Note of Chronic health care condition: Symptoms: Addical treatment necessary while at the program: Potential side effects of treatment: Potential consequences if treatment is not administered: Jame of educators that received training addressing the medical condition: Person who trained the educator (Child's Health Care Practitioner, child's parent, program dealth Care Consultant): Jame of Licensed Health Care Practitioner (please print): Jame of Licensed Health Care Practitioner authorization: Date: Jame of Children Only (9+ years of age) Jointh written parental consent and authorization of a licensed health care practitioner, this Individual ealth Care Plan permits older school age children to carry their own inhaler and/or epinephrine autification will be kept secure from access by other children in the program. Whenever an Individual ealth Care Plan provides for a child to carry his/her own medication, the licensee must maintain of the aback-up supply of the medication for use as needed. Joseph Child: Date of Birth: Back-up medication received? YES NO	Check all that apply	
Doctor or Licensed Practitioner Program's Health Care Consultant Older school age child (9+ yrs. of age) Other: Name of child: Date: Name of child: Date: No (updated physician/parental signatures required Same of chronic health care condition: Symptoms: Medical treatment necessary while at the program: Protential side effects of treatment: Protential consequences if treatment is not administered: Idame of educators that received training addressing the medical condition: Person who trained the educator (Child's Health Care Practitioner, child's parent, program lealth Care Consultant): Idame of Licensed Health Care Practitioner (please print): Idensed Health Care Practitioner authorization: Date: Dat	Plan was created by:	Plan Is maintained by:
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erent signature:Date:	age of child: Date of Birth:	_ Back-up medication received? YES NO
	Parent signature:	Date:
dministrator's signature: Date:	Administrator's signature:	Date:





Commonwealth of Massachusetts Department of Early Education and Care

Name of madissalar		
Name of medication:		
Please check one of the following: Prescription	n: Oral/Non-Prescription:	
Unanticipated Non-Prescription for mild symp	otoms	
Topical Non-Prescription (applied to open wound/broken skin)		
Dosage:		
Date(s) medication to be given:		
Times medication to be given:		
Reasons for medication:		
Possible side effects:		
Directions for storage:		
Name and phone number of the prescrib		
Child's Health Care Practitioner Signatur	e Date:	
(print name) (parent or guardian	n) give permission	
To authorize educator(s) to administer rabove.		
Parent/Guardian Signature	Date:	
For topical, non-prescription NOT applie	d to open wound/broken skin (parent	