the Y

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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
___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 Heath Care Plan? YES (indicate changes below) NO (updated physician/parental signatures required)
Name 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 comment: _____ 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 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/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: _____

YMCA OF GREATER SPRINGFIELD
Association Offices
1500 Main Street, Springfield, MA 01115 - Suite 256
P: 413.739.6951 F: 413.747.6183

MAILING ADDRESS
PO Box 15329
Springfield, MA 01115-5329
WWW.SPRINGFIELDY.ORG

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Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11 (2)(b)

Name of child: _____

Name of medication: _____

Please check one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (applied to open wound/broken skin) _____

My child has previously taken this medication _____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

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 prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____ **Date:** _____

I, _____**, (parent or guardian) give permission**
(print name)
To authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date:** _____
For topical, non-prescription NOT applied to open wound/broken skin (parent signature only)

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