Form 13. 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
__ Other: _____

Plan is maintained by:
__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

Name of child:	Date of birth:
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 (note name of medicine and dosage):	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name(s) of educator(s) that received training addressing the medical condition:	
Person who trained the educator(s) (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

I give permission for this child's parent (guardian) and/or the program's Health Care Consultant to train the educators in this child's Individual Health Care Plan.

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

Licensed Health Care Practitioner authorization: _____ Date: _____

By signing this form, I give permission for WCCC to administer the medications listed on the Action Plan provided by the Physician's Office and listed on this Individual Health Care Plan.

Parental/Guardian consent: _____ Date: _____

EEC Individual Health Care Plan Form

Name of child: Date of Birth:
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Who has been trained and will be administering this treatment while the child is at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)

Name and Phone Number of Licensed Health Care Practitioner (please print):_____

Parental/Guardian Signature: _____Date:_____

Program Administrator Signature: _____ Date:_____

For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and 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's Signature: _____ Date: _____

Program Administrator's Signature: _____ Date: _____