Individual Health Care Plan Form

Name of child: Date of plan:
Any change to the child's Health Care Plan?
YES (indicate changes) NO (physician/parental signatures required)

Plan was created by (Check all that apply):
__ 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 chronic health care condition(s):

Description of chronic health care condition(s):

Symptoms:

Medical treatment necessary while at the program:

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Names 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):

Licensed Health Care Practitioner (please print):_____
Licensed Health Care Practitioner authorization:_____ Date:_____
Parental/Guardian consent: _____ Date:_____