**Individual Health Care Plan Form**

**Plan must be renewed annually or when child’s condition changes**

*Check all that apply….*

**Plan was created by: Plan is maintained by:**

# Child’s Photo

Parent

Doctor or Licensed Practitioner

Program’s Health Care Consultant

Older school age child (9+ yrs. of age)

Other:

Director

Assistant Director

Child’s Educator

Other:

|  |
| --- |
| Name of child: Date: |
| 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: |
| 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: