Individual Health Care Plan

This form to be used for chronic health conditions. It must be signed by a Health Care Professional.
diabetes, adrenal insufficiency, seizures, lactose intolerance requiring medication etc.
Plan must be renewed annually or when child's condition changes

Check all that apply…

Plan was created by:
____ Parent / Guardian
____ Doctor or Licensed Practitioner
____ Other_____

Plan is maintained by:
____ Co -Director_____
____ Office Administrator_____
____ Other_____

THIS MUST ALL BE FILLED OUT

Child's name_____D.O.B._____ Date_____
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 Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization:X_____Date:_____

Parental / Guardian consent_____Date:_____

Name of staff who received training addressing the medical condition:
Name of person (child's health Care Practitioner, child's parent, program's health care consultant) who trained the staff: Child's Parent

For Older Children ONLY (9+ years of age) who have <u>permission to carry</u> their own medication:

With written parental consent ***<u>and</u>*** authorization of a licensed health care professional, this IHCP permits older school age children to carry their own inhaler and/or EpiPen and use them as needed without the direct supervision of an ASC staff member. The inhaler / Epipen will be stored in a zippered section of the child's backpack.

The staff members are aware of the contents and requirements of the child's IHCP specifying how the inhaler or EpiPen will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed. Back up medication received? YES NO

The child named above, age_____ has permission to carry and self administer his ☐INHALER ☐EPI-PEN

Licensed Health Care Practitioner signature:_____Date:_____

Parent/Guardian signature_____Date_____

11/16/2015

ASC signature_____Date_____

q=every, q4° = every 4 hours, BID = 2X a day, QID = 4 X a day, NOS=not otherwise specified, PO = by mouth, HS=night time,