Photo

Individual Health Care Plan
EVERY LINE MUST BE COMPLETED

CHILD'S NAME:

DATE OF BIRTH:

Check all that apply….
Plan was created by:
__Parent/Guardian
__Doctor or Licensed Practitioner
__Other:_____
Plan is maintained by: ✓ Site Coordinator

Name & description of chronic health care condition: _____

Symptoms: _____

_____

Medical treatment necessary while at program/times/date meds to be given:

_____

_____

Medication Name & Dosage: _____ Medication Name & Dosage: _____

Directions for storing medications: _____

Reasons for medication(s): _____

Potential side effects of treatment(s): _____

_____

Potential consequences if treatment is not administered: _____

Name of educators received training addressing the medical condition: **Needham Extended Day Program staff**
Person who trained the educator: **Child's parent/guardian**

My child has previously taken these medications: ____
My child has not previously taken medications: ____

I, **Parent/Guardian, authorize educator(s) to administer medication to my child as indicated above.**

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

Licensed Health Care Practitioner Authorization: _____ Date: _____

Parent/Guardian Consent: _____ Date: _____