

Individual Health Care Plan Form

PLAN MUST BE RENEWED ANNUALLY OR WHEN CHILD'S CONDITION CHANGES

Plan is maintained by the Directress and child's educators.

Check all that apply

Plan was created by:

Doctor or Licensed Practitioner

Parent

Name of child: _____ Date: _____

Any changes to the child's Health Care Plan?

YES (indicate changes below) NO (update physical/parental signatures required)

Name of chronic health condition:

Symptoms:

Medical treatment if necessary while at the program:

Potential side effects of treatment:

Potential consequence if treatment is not administered:

Name of educators that received training addressing the medical condition:

Person who trained the educator (child's parent, Health Care Practitioner, FHM Health Care Consultant):

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

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian Consent: _____ Date: _____

* This form must be accompanied by an Individual Health Plan created by your child's pediatrician.