Individual Health Care Plan Form

This form is to be used to document all of your child's health care conditions that may require treatment, including emergencies, while at school.

Name: **Date:**

Chronic Health Condition/s and or Allergies	
Name of chronic health care condition/s:	
Symptoms:	
Medical treatment necessary while at program, including medications:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name/s of trained educator/s:	
Person who trained the educator/s (i.e. health care practitioner, parent or other):	
Name of licensed health care practitioner *please print:*	**Date:**
Licensed health care practitioner (authorization) signature:	**Date:**
Parent /Guardian (consent) signature:	**Date:**

Plan was created by: ***Check all that apply***

- ☐ Parent
- ☐ Doctor of Licensed Practitioner
- ☐ Other:
- ☐

Plan is maintained by:

- ☐ Director
- ☐ Associate Director
- ☐ School Coordinator
- ☐ Teacher

Individual Health Care Plan Form

This form is to be used to document all of your child's health care conditions that may require treatment, including emergencies, while at school.