

HEALTH CARE PLAN DOCUMENTATION & PERMISSION TO ADMINISTER MEDICATION FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance and update annually and as needed when a child has a special chronic health condition that may require the program to perform a medical procedure or administer medication. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

HEALTH CARE PLAN DOCUMENTATION

Child's Name	Date of Birth
If the child does not have a special chronic health condition or diagnosis check here: <input type="checkbox"/>	
Skip to page 2 to give permission to administer medication/medical food.	
Complete a new form or provide separate documentation for each condition that requires different actions to be taken.	
<input type="checkbox"/> Check here if additional information/documentation is attached from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN). This documentation may serve as a substitute for page 1.	
Special Chronic Health Condition	
What are the signs, symptoms, or situations which require staff to take action, perform a medical procedure and/or administer medication or medical food?	
What are the activities, foods, conditions, etc. to avoid? <input type="checkbox"/> Not Applicable	
What are the instructions to care for the child or perform a medical procedure?	
If the child's health condition does not improve or side effects to medication appear, trained staff will do one or more of the following:	
<input type="checkbox"/> Call 9-1-1	
<input type="checkbox"/> Call Parent	
<input type="checkbox"/> Other:	
Additional Information and/or what is needed if the child care program must be evacuated:	
If the special health condition does not require administering medication/medical food: STOP HERE AND SKIP TO PAGE 3	
Page 1 is completed to provide instructions for performing a medical procedure.	

SIGNATURE PAGE

Child's Name

PARENT/GUARDIAN

By signing this form I attest that: (check all that apply)

- I have provided information for care or implementing a medical procedure
- I have trained staff and have given permission to perform the procedure
- I have trained staff and have given permission to administer medication to my child

Parent Signature

Date of Signature

LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE REGISTERED NURSE, LICENSED DENTIST

Health Care Professional's signature is only required in this box if their instructions have been provided on this form, prescribed medication does not have a prescription label, or as directed by the manufacturer's instructions.

Physician Signature

Date of Signature

CERTIFIED PROFESSIONAL TRAINER

(A signature from a Certified Professional Trainer is not required if the parent/guardian has provided instructions for care, training, or administering medication)

If a Certified Professional Trainer provided instructions, my signature indicates that:

- I have provided instructions for care and/or training for the medical procedure.
- I have provided instructions for administering medication.

Certified Professionals Name (please print)

Phone Number

Certified Professionals Signature

Date of Signature

PROGRAM STAFF

Signatures of all individuals who have received instructions for care, have been trained in performing the procedure for this child and/or administering medication. Additional names and signatures can be attached on a separate sheet.

Printed Name	Signature	Date

