Springfield College
Child Development Center
715 Wilbraham Road, Springfield, MA 01109
(413) 788-2451

Individual Health Care Plan Form

Plan must be renewed annually or when the child's condition changes.

Check all that apply:

Plan was created by:

___ Parent
___ Doctor or Licensed Practitioner
___ Program's Health Care Consultant
___ Older School Age Child (9+ years of age)
___ Other: _____

Plan is maintained by:

___ Director
___ Assistant Director
___ Child's Educator
___ Other: _____

Place Child's Picture Here

Name of Child: _____ Date: _____

Any change to the child's health care plan?

☐ **YES** (indicate changes below) ☐ **NO** (updated physician/parental signatures required)

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 Educators that Received Training Addressing the Medical Condition:

_____

Name of Person Who Trained the Educator (child's health care practitioner, child's parent, program's health care consultant):

_____

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

Licensed Health Care Practitioner Authorization: _____ Date: _____

Parental/Guardian Consent: _____ Date: _____

For Older Children Only (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this individual health care plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and used them as needed without direct supervision of an educator.

The educator is aware of the contents and requirements of the child's individual health care plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an individual health care pan provides for a child to carry his or her own medication, the licensee must maintain a back-up supply of the medication on site for use as needed.

Age of Child: _____ Date of Birth: _____ Back-up medication received? YES NO

Parent Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____