

**Individual Health Care Plan Form**

Plan must be renewed annually or when 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+ yrs. of age)
- Other: Membership Director WSBG Club

**Plan is maintained by:**

- Director
- Assistant Director
- Child's Educator
- Other: Membership Dept. WSBG Club

Name of child:	Date:
Any change to the child's Health Care Plan? <b>YES</b> (indicate changes below) <b>NO</b> (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: <u>All WSBG Club Staff are Trained</u>	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant): <u>EEC Medication Administration Training</u>	

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 use them as needed without the 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 Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Back-up medication received? YES NO

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Commonwealth of Massachusetts  
Department of Early Education and Care

**MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)**

Name of child: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Please ✓ one of the following: Prescription: \_\_\_\_\_ Oral/Non-Prescription: \_\_\_\_\_

Unanticipated Non-Prescription for mild symptoms \_\_\_\_\_

Topical Non-Prescription (**applied to open wound/ broken skin**) \_\_\_\_\_

My child has previously taken this medication \_\_\_\_\_

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan \_\_\_\_\_

Dosage: \_\_\_\_\_

Date(s) medication to be given: \_\_\_\_\_

Times medication to be given: \_\_\_\_\_

Reasons for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

Name and phone number of the prescribing health care practitioner:  
\_\_\_\_\_

**Child's Health Care Practitioner Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I, \_\_\_\_\_, (parent or guardian) gives permission  
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)