INDIVIDUAL HEALTH CARE PLAN FORM

Name of child:	Date of Birth:
Name of chronic health care conditions:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name and Phone Number of Licensed Health Care Practitioner (please print):

_____

Parent/Guardian Signature: _____ Date: _____

Program Admin. Signature: _____ Date: _____

MEDICATION ADMINISTRATION

Please fill out a Medication Consent Form for each medication the program may need to administer.

Medication that will be administered at the program must be provided by a parent/guardian in the original container(s) bearing the pharmacy label with the following information:

_____ the date of filling
_____ the pharmacy name and address
_____ the filling pharmacist's initials
_____ the serial number of the prescription
_____ the name of the patient
_____ the name of the prescribing practitioner
_____ the name of the prescribed medication
_____ directions for use and cautionary statements contained in such prescription or required by law
_____ if tablets or capsules, the number in the container

All over-the-counter medications must be kept in the original containers containing the original label, which shall include the directions for use

FOR OLDER CHILDREN ONLY (9+ YEARS OF AGE)

In accordance with 606 CMR 7.11(3)(b-c) and 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/Guardian Signature: _____ **Date:** _____

Program Admin. 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 select 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 <u>not</u> 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 to

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

Parent/Guardian Signature: _____ Date: _____

For topical, non-prescription <u>NOT</u> applied to open wound / broken skin (parent signature only)