Southborough Extended Day Program
Individual Health Care Plan Form

Child's Name: _____
DOB: _____

Child's Photo

Instructions:

This form must be completed by a parent/guardian for any child with a chronic health condition.
A new form must be completed annually.

- *Please attach any additional information that is pertinent to the child's care.*
- *The child's Licensed Health Care Practitioner must authorize this plan by signing this form.*
- *This plan must be updated with new physician/parental signatures when the child's condition changes.*
- *If the child has food allergies a Food Allergy Action Plan must be completed*

Check all that apply….

Plan was created by:
__ Parent/Guardian
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant

Plan is maintained by:
__ Executive Director
__ Site Coordinator
__ SEDP Staff

Child's Name:	**DOB:**
Name of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program (include dosage and time needed):	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition: Any SEDP staff who have taken the "5 Rights of Medication" training, have current First Aid Certification, and have been trained by someone listed below.	
Person who trained the educator: Child's Parent	

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.

Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

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

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____