



Attach Child's Photo Here (Optional)

Individual Health Care Plan for Chronic Conditions

Required by the EEC and must be renewed annually or when condition changes

Please complete all highlighted sections

Check all that apply. Plan was created by: [checkbox] Parent, [checkbox] Doctor or Licensed Practitioner, [checkbox] Program's Health Care Consultant, [checkbox] Older school age child (9+ years of age), [checkbox] Other: _____. Plan is maintained by: [checkbox] Program Director, [checkbox] Site Director, [checkbox] Child's Educator, [checkbox] Other: _____.

Child's name: _____

Date plan was created: _____

Any change to the child's Health Care Plan?

- [checkbox] Yes (Indicate changes below)
[checkbox] 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:

Back up medication received? Yes No
(Two Epi-Pens are required)

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Name of educators that received training addressing the medical condition:

ALL SIGNATURES REQUIRED

Name of person who trained the educator (*health care practitioner, parent, or program's health care consultant*):

Name of Licensed Health Care Practitioner: _____

Licensed Health Care Practitioner Authorization (Signature): _____

Date: _____

Parent/Guardian/Caregiver Consent (Signature): _____
