

# Individual Health Care Plan Form

Child's Photo

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

**PLEASE COMPLETE ALL SECTIONS.**

**Check all that apply:**

**Plan was created by:**

Parent       Doctor or Licensed Practitioner  
 Program's Health Care Consultant     Other: \_\_\_\_\_

**Plan is maintained by:**

Director       Program Coordinator  
 Child's Educator     Other: \_\_\_\_\_

<b>Name of child:</b>	<b>Date:</b>
<b>Any change to the child's Health Care Plan?</b>	
YES (indicate changes below)      NO (updated physician/parental signatures required)	
<b>Name of chronic health care condition:</b>	
<b>Description of chronic health care condition:</b> Please be specific (if asthma, what are causes? If food allergy, is it just ingestion or exposure too?)	
<b>Symptoms:</b>	
<b>Medical treatment necessary while at the program:</b>	
<b>Potential side effects of treatment:</b>	
<b>Potential consequences if treatment is not administered:</b>	
All BASCP employees administering medication have taken the 5 rights of medication training and have been trained by: Diana Chanell, CRTT, Solo WFA Certified or by a trained member of the BASCP Leadership team.	

Name of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Licensed Health Care Practitioner Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

Parental/Guardian Consent: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*CONSENT INCLUSION DATES RUN FROM DATE OF SIGNATURE THROUGH JUNE 30, 2019.**