

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: _____

Name of child:	Date:
Any change to the child's Health Care Plan?	
YES (indicate changes below) NO (updated physician/parental signatures required)	
Name of chronic health care condition:	
Description of chronic health care condition: Please be specific (if asthma, what are causes? If food allergy, is it just ingestion or exposure too?)	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
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, 2018.**