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 a certified 1st Aid/CPR instructor or by parent of child.

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, 2024*******