My Health Care Plan – Child Care *Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Medical Record #*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Controller Medication** | **Dosage** | **How Often** | **Other Instruction** |
|  |  | \_\_\_\_\_\_\_ times per day  **EVERY DAY!** |  |
|  |  | \_\_\_\_\_\_\_ times per day |  |
|  |  | **EVERY DAY!** |  |
|  |  | \_\_\_\_\_\_\_ times per day |  |
|  |  | \_\_\_\_\_\_\_ times per day  **EVERY DAY!** |  |
|  |  | \_\_\_\_\_\_\_ times per day |  |
|  |  | **EVERY DAY!** |  |
|  |  | \_\_\_\_\_\_\_ times per day |  |
| **Quick Relief Medications** | **Dosage** | **How Often** | **Other Instructions** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please describe a medical alert. Child care providers should be aware of the warning signs described below and take the following action:

**GET HELP IMMEDIATELY BY DIALING 911 IF THE CHILD IS EXIBITING ANY OF THE FOLLOWING SYMPTOMS OR BEHAVIORS:**

**Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. This authorization is for a maximum of one year from signature date.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Healthcare Provider Signature Date**

Individual Child Health Plan

|  |  |
| --- | --- |
| Parent/Guardian Signature | Date |
|  |  |
| Health Care Provider’s Signature | Date |
|  |  |
| Health Care Provider’s Name (Print): |  |
| Health Care Provider’s Agency: |  |

Emergency Contact Information

|  |  |  |
| --- | --- | --- |
| Parent/Guardian #1 | Phone | Phone |
|  |  |  |
| Parent/Guardian #2 | Phone | Phone |
|  |  |  |
| Emergency Contact #1 |  |  |
|  | Phone | Phone |
| Emergency Contact #2 |  |  |
|  | Phone | Phone |

*Special Instructions*:

Staff Training Information

|  |  |  |
| --- | --- | --- |
| Staff Name | Trainer (parent or guardian) | Date |
| Casey Lalonde |  |  |
| Donna Simon |  |  |
|  |  |  |
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