Department of Public Health and Human Services
Child Care Licensing Bureau

Health Care/Medication Plan

-To be approved by a Health Care Provider-

Today's Date	
Child' Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Primary Health Care Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

For Behavior Changes: _____

Additional comments: _____

_____

SPECIAL NEEDS HEALTH CARE PLAN

-continued-

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of the child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*