CHILD HEALTH PLAN

To be completed by Parent/Guardian:

Child's Name:	DOB: M_____	Sex: F_____
Parent/Guardian's Name:	Phone:	
Parent/Guardian's Name:	Phone:	
Emergency Contact/s:	Phone:	

To be completed by the Health Care Provider:

Health Concern: Asthma____ Seizure disorder_____ Diabetes _____ Allergy_____ Other_____
Signs/Symptom to look for:
Treatment Plan/Emergency Procedure:

Does treatment include medication: Yes ___ No___

If yes please complete the following:

Medication	Dosage	Route	Time/ Frequency	Possible side effects	Start date	Stop Date

Document any medication given on the Medication Administration Record (see back of this form)

Does this child require a 3 day emergency supply of medication at Child Care/ Head Start/ ECEAP?

Yes _____ No_____

Place child's picture here

If yes please make sure this child has a 3 day supply of medication on hand with appropriate medication forms filled out.

Parent/Guardian's Signature_____ _____
Date:_____

Health Care Provider's Signature:_____Phone:_____

Date:_____

Staff

signature_____Date:_____

Place child's picture here

Medication Administration Record

Child's Name_____ Date of Birth_____

Medication given	Date given (MM/DD/ YYYY)	Route	Dose given	Time given	Initials of person giving medication

Initials and Signature of person administering medications:

_____
_____
_____
_____
_____