YMCA SOUTHCOAST

Individual Health Care Plan

Plan must be renewed annually or when child's condition changes

Check all that apply....

Plan was created by:

__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Other: _____

Plan is maintained by:

__ Director
__ Assistant Director
__ 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)
Chronic health condition
Description of chronic health care condition:
Symptoms of the health care condition:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

For any medication to be given at the Childcare Program the following must be provided

- Medication must be in its original box
- Medication Order from the physician
- Medical Consent Form
- Signed Individual Health Care Plan (this form) by the physician

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

Updated 5/2019

YMCA SOUTHCOAST
Medical Consent Form

PLEASE PRINT LEGIBLY

CHILD'S NAME _____ Birth Date _____ Male ☐ Female ☐

Address _____

City _____ State _____ Zip _____

Child's Health Care Practitioner Name _____

Practitioner's Phone _____

Parent's Name _____ Parent's Phone _____

Please √ one of the following : Prescription ☐ Oral/Non-prescription ☐

Unanticipated Non-Prescription for mild symptoms ☐

Topical Non-Prescription **(applied to open wound/broken skin)** ☐

My child has previously taken this medication ☐

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan ☐

Name of Medication _____

Dosage _____

Date(s) medication to be given _____

Time(s) medication to be given _____

Reasons for medication _____

Possible side effects _____

Directions for storage _____

_____ _____

Child's Health Care Practitioner Signature **Date**

I, _____ give permission to authorize educator(s) to administer medication to my child as indicated above.
Parent · Guardian

_____ _____

Parent · Guardian Signature **Date**

For topical, non-prescription **NOT** applied to open wound/broken skin **(parent signature only)**