



### Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name and Phone Number of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Parental/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medication Administration

Please fill out a **Medication Consent Form** for each medication the program may need to administer.

Medication that will be administered at the program must be provided by a parent/guardian in the original container(s) bearing the **pharmacy label with the following information:**

- \_\_ the date of filling
- \_\_ the pharmacy name and address
- \_\_ the filling pharmacist's initials
- \_\_ the serial number of the prescription
- \_\_ the name of the patient
- \_\_ the name of the prescribing practitioner
- \_\_ the name of the prescribed medication
- \_\_ directions for use and cautionary statements contained in such prescription or required by law
- \_\_ if tablets or capsules, the number in the container

All over-the-counter medications must be kept in the original containers containing the original label, which shall include the directions for use

### For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and with written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Back-up medication received? YES NO

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Commonwealth of Massachusetts  
Department of Early Education and Care

**MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)**

Name of child: \_\_\_\_\_

Name of medication: \_\_\_\_\_

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 \_\_\_\_\_

Dosage: \_\_\_\_\_

Date(s) medication to be given: \_\_\_\_\_

Times medication to be given: \_\_\_\_\_

Reasons for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

Name and phone number of the prescribing health care practitioner:  
\_\_\_\_\_

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

I, \_\_\_\_\_, (parent or guardian) gives permission  
(print name)

**to authorize educator(s) to administer medication to my child as indicated above.**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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