Individual Health Care Plan Form

Name of child: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, ...	Date of Birth: 04/28/1980
Name of chronic health care condition: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse potenti.	
Description of chronic health care condition: Aenean sit amet justo.	
Symptoms: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse potenti.	
Medical treatment necessary while at the program: Aenean sit amet justo.	
Who has been trained and will be administering this treatment while the child is at the program: Aenean sit amet justo.	
Potential side effects of treatment: Aenean sit amet justo.	
Potential consequences if treatment is not administered: Aenean sit amet justo.	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.) Aenean sit amet justo.	

Name and Phone Number of Licensed Health Care Practitioner (please print): Duis ac nibh. Fusce lacus purus, aliquet at, feugiat ...

Parental/Guardian Signature: Signed at: 2026-08-15 16:13:23 Date: 04/28/1980

Program Administrator Signature: Signed at: 2026-08-15 16:13:23 Date: 04/28/1980

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**:
04/ the date of filling
Duis the pharmacy name and address
Duis the filling pharmacist's initials
Duis the serial number of the prescription
Duis the name of the patient
Duis the name of the prescribing practitioner
Duis the name of the prescribed medication
Duis directions for use and cautionary statements contained in such prescription or required by law
Duis 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: Duis ac nibh. ... Date of birth: 04/28/1980 Back-up medication received? NO YES NO

Parent's Signature: Signed at: 2026-08-15 16:13:23 Date: 04/28/1980

Program Administrator's Signature: Signed at: 2026-08-15 16:13:23 Date: 04/28/1980

Commonwealth of Massachusetts
Department of Early Education and Care

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

Name of child: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse potenti.

Name of medication: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse ...

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 .....

My child has **no**t 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: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse potenti.

Date(s) medication to be given: 04/28/1980

Times medication to be given: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. ...

Reasons for medication: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse potenti.

Possible side effects: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse ...

Directions for storage: Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, pretium quis, lectus. Suspendisse ...

Name and phone number of the prescribing health care practitioner:

Duis ac nibh. Fusce lacus purus, aliquet at, feugiat non, ...

Child's Health Care Practitioner Signature Signed at: 2026-08-15 16:13:23 **Date** 04/28/1980

I, _____, (parent or guardian) gives permission
(print name)

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

Parent/Guardian Signature Signed at: 2026-08-15 16:13:23 **Date** 04/28/1980
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**