Medfield Afterschool Program

Individual Health Care Plan Form

Attach Photo

USE THIS FORM FOR: *Any chronic condition or illness such as: asthma, ADD/ADHD, celiac disease, diabetes, epilepsy, and non-severe allergies which require medical treatment. Please contact your child's program director to set up a time to review: health condition forms, to drop off required medication if necessary, and provide training.* Plan must be renewed annually *and updated* when/*if* child's condition changes.

Check all that apply…

Plan was created by:
- ☐ Parent/Guardian
- ☐ Doctor or Licensed Practitioner
- ☐ Other: _____

Plan is maintained by:
- ☐ Director
- ☐ Lead Teacher
- ☐ Educators

Name: _____ Grade/Program: _____ Date of Birth: _____

Parent/Guardian: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Description of chronic health care condition: _____

What symptoms should educators be aware of and looking for (be specific): _____

_____

If these symptoms occur, what steps should be followed by the educators (including when to start specific medical treatments, when to inform parents/guardians, etc.)?

_____

_____

_____

What are the potential side effects of the treatment? _____

What are the potential consequences if treatment is not administered? _____

Does the child have the same medication or other medications at school that may be administered before they arrive at MAP and that would require the MAP staff to know when it was last taken?

☐ **NO** ☐ **YES** (if yes, answer the follow up question)

If yes, do you give your child's school nurse permission to contact MAP and/or for MAP to contact the nurse to see if any such medication was administered during the child's school day?

☐ **NO** ☐ **YES**

I, _____, the parent/guardian, will provide the MAP Staff with training that specifically addresses the child's condition, allergy, medication, and or other treatment needs.

I give permission for MAP to administer the above treatment, including the administration of the medications specified.

Doctor's/Provider's Signature: _____ Date: _____

Print Name of Doctor/Provider: _____ Office Phone: _____

Parent's/Guardian's Signature: _____ Date: _____

To be filled out by MAP | Name of educators that received training addressing the medical condition:

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INDIVIDUAL HEALTH CARE PLAN
MEDICATION CONSENT FORM

(only one medication per form)

To be filled out on the child's last day
Date returned:_____

Parent/Guardian Signature:

To be filled out by child's parent/guardian:

Name of Child: _____ Name of Medication:_____
(one medication per form)

☐ Prescription ☐ Non-Prescription *(A PHYSICIAN'S SIGNATURE is REQUIRED if the medication is NOT a prescription OR is for a chronic condition requiring training on the medical condition or administration of required medication*

Type of Medication: ☐ Liquid ☐ Pill (# Pills if prescription ____) ☐ Other _____

Dosage _____ (must match what the Licensed Health Care Practitioner authorized on the Individual Health Care Plan)

Storage Directions: _____

When should this medication be given? (Be specific, including symptoms that would cause your child to necessitate this medication. (Must match what the Licensed Health Care Practitioner authorized on the Individual Health Care Plan)

_____

_____

Date of 1st Dose _____ (MAP is not allowed to administer the 1st dose of a medication unless it is an emergency medication such as an EPI Pen)

- ☐ I have submitted to MAP their completed "Individual Health Care Plan" that was signed by the child's doctor and parent/guardian.
- ☐ I give permission to authorized MAP educators to administer medication to my child as indicated on the signed "Individual Health Care Plan".

Parent/Guardian Signature: _____ Date: _____

To be filled out by MAP Staff:

Medication Administration Record

☐ Original prescription label on the medicine container
☐ Name of the child on the container ☐ Date on prescription current ☐ Expiration Date _____
☐ Dose, name of drug, frequency of administration on the label consistent with instructions

CHILD'S NAME: _____ *MEDICATION:* _____

Date	Time	Medication	Dose	Route	Staff Signature	Miss dose Errors	Child Refusal (✓)

**If child refused medication, explain why and attach to administration record.*

This record must be maintained in the child's file when complete

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