Medfield Afterschool Program

Individual Health Care Plan Form

Plan must be renewed annually and updated when/if child's condition changes.

Attach Child's Photo

USE THIS FORM FOR: *Any chronic medical condition which has been diagnosed by a doctor or licensed health care practitioner, such as allergies, asthma, ADD/ADHD, celiac disease, diabetes, epilepsy, etc. which requires medical treatment. Please contact your child's program director to set up a time to review this form, discuss health condition, drop off medication if necessary, and provide training.*

Check all that apply…

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

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

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

Parent/Guardian:_____

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

Parent/Guardian:_____

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

Chronic health care condition:_____

Description of chronic health care condition: _____

Symptoms (be specific): _____

_____

Medical treatment necessary while at the program:

Potential side effects of treatment?

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? ☐ **YES** ☐ **NO** **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? ☐ **YES** ☐ **NO**

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.

Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner Authorization/Signature: _____Date:_____

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

Medfield Afterschool Program

INDIVIDUAL HEALTH CARE PLAN
MEDICATION CONSENT FORM

(only one medication per form & in original container)

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

Parent/Guardian Signature:

TO BE COMPLETED BY CHILD'S PARENT/GUARDIAN:

Name of Child: _____ Chronic Condition: _____

Name of Medication:_____ (one medication per form)
*If Non-Prescription, a *Licensed Health Care Practitioner signature is required*

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

Storage Directions: _____

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

Date of 1st Dose _____ (MAP cannot administer the 1st dose of a medication unless it is an emergency medication)

When should this medication be given? (Be specific, including symptoms that would cause your child to necessitate this medication.)

I give permission to MAP to administer the above medication per the directions above.

Parent/Guardian Signature: _____ Date: _____

REQUIRED IF NON-PRESCRIPTION

Licensed Health Care Practitioner *(please print)*: _____

Licensed Health Care Practitioner Authorization/Signature: _____Date: _____

MEDICATION ADMINISTRATION RECORD

COMPLETED BY MAP STAFF:

☐ Who trained the staff: _____ ☐ Medication Consent Form Completed
☐ Original prescription label on the medicine container ☐ Name of the child on the container
☐ Date on prescription current (good for 1 year from date prescription filled) ☐ Expiration Date _____
☐ Dose, name of drug, frequency of administration given on the label match parent/guardian instructions
☐ 5 rights addressed (right child, right medication, right dose, right route & right time)

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

JS- K-1 Program (508) 359-2165
Meghan.map@comcast.net

2-3 Program (508) 359-8513
Alex.23map@gmail.com

MAP @ Pfaff Program (508) 359-2168
kurt14.map@gmail.com

Medfield Afterschool Program, Inc.

Health History, Training & Program Considerations

To be filled out by Program Director/Lead Educator during the parent/guardian meeting and attached to the severe allergy action plan or individual health care plan.

Please contact your child's Program Director once you have all of the forms completed, including the signature of a licensed health care practitioner, and required medication (if any) in the original box. This meeting is required prior to your child's attendance at MAP.

Meghan Jackson
JS- K-1 Program (508) 359-2165
Meghan.map@comcast.net

Alex Sakash
2-3 Program (508) 359-8513
Alex.23map@gmail.com

Kurt Jackson
MAP @ Pfaff Program (508) 359-2168
kurt14.map@gmail.com

Child's Name: _____ *Program:* _____

*Date of Meeting:*_____ *Parent Guardian:* _____

Training:

Severe Allergy: Has your child ever needed to have an epinephrine injection or inhaler? _____How many times? _____

Other Emergency Medication: _____

Last time used:_____ For What Symptoms: _____

Does your child need to ingest the allergen to have a reaction? _____

Does your child require special seating when having snack or lunch? _____

Will you be sending in special snacks? _____

Information and special considerations for when the child is in MAP's care:_____

_____

_____

_____

_____

_____

Individual Health Care Plan: Information and special considerations for when the child is in MAP's care: _____

_____

_____

_____

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_____

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_____

Program Director/Lead Educator Signature: _____ Date: _____