Early Learning Essentials

CHILD HEALTH PLAN

Child _____ Birth date _____

Parent / Guardian _____ Phone # _____

For their own safety, any child who needs a Health Plan or an Authorization to Administer Medication form will not be allowed to attend class until this form has been signed by a physician and returned to our Administrative Office.

To Health Care Provider: Please complete the following information for the above-named child.

MEDICAL CONDITION

Health Plan is needed due to the following diagnosed medical condition/conditions:

1._____

2._____

3._____

ROUTINE CARE

☐ YES ☐ NO **Does this condition require any special accommodations in the classroom**? If yes, please describe in box below.

MANAGEMENT

This condition is: (check all that apply)

☐ Life threatening and may require/requires that medication that must be administered while child is at school. *

☐ Non life threatening and may require/requires medication/medical attention that must be administered while at school. *

☐ Non life threatening and does not require that medication be administered while at school.

*A completed Authorization to Administer Medication form MUST accompany all health plans that require or may require any medication or emergency medication to be administered to a child while at school.

HEALTH CARE PROVIDER: I authorize Head Start staff to implement this Health Plan while the above-named child is at Head Start.

_____	_____	_____	_____
Health Care Provider & Title (Please Print)	Health Care Provider's Signature	Date	Phone Number

PARENT/GUARDIAN: I will contact the Mountainland Head Start, Inc. Health Services Coordinator if there are changes to this plan.

_____	_____	_____
Parent or Guardian's Name (Please Print)	Parent or Guardian's Signature	Date

FOR OFFICE USE ONLY : HSC/NSC REVIEW & ENTRY _____ → HS review & file _____ Teacher Initials _____

Initial & Date Cook Initials if due to SMP _____