This page to be completed by:
Program Staff and Parent or Guardian

Public Health
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Individual Care Plan Request Form

Child's Name: _____

Child's Date of Birth: _____

Early Learning or Child Care Program Director: _____

Early Learning or Child Care Program: _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

Authorizing Provider or Professional: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans.

- **Healthcare providers** (MD, PA, ARNP, ND, or DO): please complete and sign pages 2-7, as applicable.
- **Licensed or certified professionals** (registered nurse, mental health professional, educator, or social worker): please complete and sign pages 2-4, as applicable.

By signing below, I give permission to my child's Authorizing Provider or Professional to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

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Individual Care Plan

Authorizing Provider or Professional: If the child has been diagnosed with allergies, asthma, diabetes, food intolerance, or seizures, please contact the program listed on page 1 to request the appropriate care plan packet.

Child's name: _____

Child's date of birth: _____

Medical or behavioral condition(s) (if known)**:** _____

_____

Emergency Response Plan

Call parent or guardian if the following medical or behavioral symptoms are present:
Call 911 Emergency Medical Services (EMS) and emergency contacts if the following symptoms are present:
Steps to take while waiting for EMS to arrive:
Additional authorizing provider or professional notes:

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Specific Care and Treatment Instructions

Child's name: _____

Dietary or Feeding Modifications (not related to food allergy or food intolerance)**:**
Environmental and Activity Modifications (for example: classroom layout, diapering, toileting, naptime or sleeping, outdoor play)**:**
Behavioral Modifications (for example: redirection techniques, activity transition needs)**:**
Special Equipment and Medical Supplies (communication equipment, chairs, sensory toys, durable medical equipment [DME])**:**
Triggers or Stimuli to Avoid:
Suggested Skills or Training for Teachers (for example: pediatric first aid, CPR for special health care needs)**:**

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Care Schedule

Child's name: _____

Time	Care Needs

Authorizing Provider or Professional: By signing below, I authorize the instructions written on pages 2-4 of this Individual Care Plan.

Title of Authorizing Provider or Professional (e.g., MD, RN, LICSW)**:** _____

Authorizing Provider or Professional Name (Printed)**:** _____

Authorizing Provider or Professional Signature: _____

Authorizing Provider or Professional Phone Number: _____

Date: _____

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Medication Authorization Form

Early Learning or Child Care Program Staff: Medications must be given as directed by the medication label or packaging. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form. Each medication must have its own Medication Authorization Form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give the medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication): _____

How much medication to give (must include dose of medication): _____

How long to give the medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year): _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.): _____

Medication requires special storage: ☐Yes ☐No

If yes, specify (for example: refrigerate; keep away from light; etc.): _____

Additional instructions: _____

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

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3-Day Supply of Medication Authorization Form

This form is for any life-sustaining daily medication that the child usually takes when not in care.

Healthcare Provider and Parent or Guardian: In the event the child needs to remain at the program past usual hours, a 3-day supply of daily **life-sustaining** medication(s) must be kept at the program. A new Authorization Form should be completed if there are changes to the medication or child's health condition.

Program Staff: This **life-sustaining** medication will only be given if the child needs to remain at the program past usual hours. Each medication requires its own completed authorization form. Never give expired medication. Expired medication must be replaced, and the updated expiration date must be added to this form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

How much medication to give (must include dose of medication)**:** _____

How long to give medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

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3-Day Supply of Medication Authorization Form (Continued)

Medication requires special storage: ☐ Yes ☐ No

If yes, specify (for example: refrigerate; keep away from light; etc.)**:**_____

Additional instructions: _____

Parent or Guardian: By signing below, I give the program permission to give this medication to my child as described on this Authorization Form.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Healthcare Provider: By signing below, I acknowledge that this child requires a 3-day supply of daily life-sustaining medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

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Additional Requirements for Care Plans

Program Staff and Parent or Guardian: The WAC requires a parent, guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of	**Employee**	**Employee**	**Trainer Name**	**Trainer**

Additional Parent or Guardian Notes:

Program Staff and Parent or Guardian: The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

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Visiting Health Professionals

Child's name: _____

Parent or Guardian: The WAC requires a child's parent or guardian to provide written consent to allow visiting health professionals (for example: speech or occupational therapist) to provide services while the child is at the program. Please complete the following information for any visiting health professionals or agencies for your child.

Care Team Member #1

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

Care Team Member #2

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

Care Team Member #3

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

By signing below, I give these visiting health professionals or agencies permission to provide services to my child while at the program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

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Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

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Medication Log

Program Staff: Please print a copy of this Medication Log for each medication in the care plan.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications

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Controlled Substance Medication Log

Program Staff: Some medications are "controlled substances," meaning the medication is regulated by the federal government due to potential for abuse. Examples include certain medications for pain, ADHD, and seizures. Each controlled substance must have its own Controlled Substance Medication Log. Controlled substances must be stored in a locked container or cabinet.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Amount or quantity of medication received by program: _____

Signature of program director: _____

Signature of parent or guardian: _____

Amount or quantity of medication returned to parent or guardian: _____

Signature of program director: _____

Signature of parent or guardian: _____

Date	Time	Dose	Starting Amount or Quantity	Amount or Quantity Given	Staff 1 *Initials	Staff 2 *Initials (Witness)

Date	Time	Dose	Starting Amount or Quantity	Amount or Quantity Given	Staff 1 *Initials	Staff 2 *Initials (Witness)

***Initials and signatures of individuals giving the medication and witnessing the medication administration:**

Initials	Printed Name and Signature of Staff 1 and Staff 2