YMCA SOUTHCOAST
Individual Health Care Plan

Plan must be renewed annually or when child’s condition changes

Check all that apply....

Plan was created by:

___ Parent
___ Doctor or Licensed Practitioner
___ Program’s Health Care Consultant
___ Other: __________________________

Plan is maintained by:

___ Director
___ Assistant Director
___ Child’s Educator
___ Other: __________________________

Name of child: ______________________ Date: ______________________

Any change to the child’s Health Care Plan?

YES (indicate changes below) NO (updated physician/parental signatures required)

Chronic health condition

Description of chronic health care condition:

Symptoms of the health care condition:

Medical treatment necessary while at the program:

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Name of educators that received training addressing the medical condition:

Person who trained the educator (child’s Health Care Practitioner, child’s parent, program’s Health Care Consultant):

For any medication to be given at the Childcare Program the following must be provided

– Medication must be in its original box
– Medication Order from the physician
– Medical Consent Form
– Signed Individual Health Care Plan (this form) by the physician

Name of Licensed Health Care Practitioner (please print): __________________________

Licensed Health Care Practitioner authorization: __________________________ Date: __________

Parental/Guardian consent: __________________________ Date: __________

Updated 5/2019
YMCA SOUTHCOAST
Medical Consent Form

PLEASE PRINT LEGIBLY

CHILD’S NAME ___________________________________________ Birth Date ___________ Male ☐  Female ☐

Address ________________________________________________

City ___________________________ State _________________ Zip ___________ 

Child’s Health Care Practitioner Name ________________________________________________

Practitioner’s Phone ________________________________

Parent’s Name ___________________________ Parent’s Phone _______________________________

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 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 ☐

Name of Medication ___________________________________________

Dosage ___________________________________________________

Date(s) medication to be given ___________________________________

Time(s) medication to be given _________________________________

Reasons for medication _______________________________________

Possible side effects _________________________________________

Directions for storage _______________________________________

__________________________ ________________________________
Child’s Health Care Practitioner Signature  Date

I, ___________________________ give permission to authorize educator(s) to administer medication to my child as indicated above.

__________________________________________________________
Parent ∙ Guardian

__________________________ ________________________________
Parent ∙ Guardian Signature  Date

For topical, non-prescription NOT applied to open wound/broken skin (parent signature only)