Forms Checklist

Please use this checklist as a helpful reminder of all the forms that must be completed prior to your child's first day.

The information in these forms are required by the Department of Public Health. They must be completed and kept on file to maintain compliance with licensing authorities and for the safety of your child. **If we do not receive the forms on time, we may need to arrange an alternate start date for your child.**

Enrollment Request Form

FACE SHEET ~ First Aid and Emergency Medical Consent form

Developmental History

Current Health Form with results of a ***physical exam within one year, lead test. and record of immunizations, signed by Health Care Provider***

Parental Consent Form: Sunscreen, Diaper Cream, Classroom Observations

Transportation Plan and Release Authorization

Email Communication Form

Photo Release Form

Complete the following forms if applicable:

Medication Consent Form (if applicable)

Individual Health Care Plan (if applicable)

Allery Action Plan (if applicable)

If your child has a chronic medical condition or allergies that require medication or treatment at school, or if you will be bringing medication of any kind to school (prescription or over-the-counter), make sure you have noted this on the applicable forms and that you and your child's health care provider have completed the required forms.

PCCD Early Intervention Playgroups
32 Osgood Street, Andover, MA 01810 T: 978-475-3806
W: www.theprofessionalcenter.org

The Professional Center for Child Development

Child's Name ____________________
Date of Birth ____________________
Home Address ____________________
Home Phone __________ EI Community

FACE SHEET ~ First Aid and Emergency Medical Consent Form

Parent/Guardian:________________	Parent/Guardian:________________
Address:________________	Address:________________
Home phone: ________________	Home phone: ________________
Occupation:________________	Occupation:________________
Place of Work: ________________	Place of Work: ________________
Work hours: ________________	Work hours: ________________
Work address: ________________	Work address: ________________
Work phone: ________________	Work phone: ________________
Mobile phone: ________________	Mobile phone: ________________
Email: ________________	Email: ________________

Child's Allergies ________________________________

Chronic Health Conditions ____________________________

Child's Physician ________________ Telephone________________

Health Insurance Coverage ____________ Policy ________________

Please list any medications being taken (at home or at school), and possible side effects

____

Emergency Contacts:

Please list two people who live locally who you authorize to pick up your child. We will contact these people if we are unable to reach you in case of emergency, or if your child needs to be picked up and you are unable to do so.

1. Name:________________ Address:________________
   Relationship to Child: ____________ Phone #: ________________
2. Name:________________ Address:________________
   Relationship to Child: ____________ Phone #: ________________

I,________________, authorize the PCCD staff, who are trained in the basics of first aid, to administer first aid to my child when appropriate. In case of a medical emergency, I authorize PCCD staff to administer CPR to my child and/or transport my child to the nearest medical facility for medical treatment, including but not limited to an epinephrine auto-injection for suspected exposure to a life-threatening allergen, when I cannot be reached or when delay would be dangerous to my child's health. In addition, I give the school permission to contact my child's physician/medical office when necessary.

Parent/Guardian Signature:________________ **Date:** ____________

Print Name: ________________________________

The Professional Center for Child Development

Developmental History

What would you like us to call your child at school? ___________________________

Family Information

Please describe who lives in the child's home (one parent/guardian, both parents/guardians, other members of the household):___________________________

What does your child call family members?___________________________

Is this child adopted?__________ If yes, at what age? __________________

Language(s) spoken at home: ___________________________

Are books read in languages other than English?___________________________

Are there words in home language that we should know?___________________________

Does your child use any special words to describe needs?___________________________

Please tell us about any cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful:

Developmental History

Weight at birth__________ Complications during pregnancy?__________________

Any known complications at birth? ___________________________

Age child began sitting: ________ crawling: ________ walking:________talking: ________

Any speech difficulties? ___________________________

List any concerns about your child's development:

Has your child been evaluated for a developmental issue? __________________

If yes, please indicate the date and describe the findings of the evaluation:

Has your child ever been diagnosed with a special need?__________________

If so, is he/she receiving any Early Intervention Services and/or have an IFSP?

____

Health/Development

Allergies (including food, environmental, drug reactions, insect bites):

____

Regular medications:____

Serious illnesses and hospitalizations:_____________________________________

Any history of colic? ____

Special physical conditions, disabilities:

____

Eating Habits

Special characteristics or difficulties: ______________________________________

Favorite foods: ____

Foods refused: ____

Child eats with: ❒ hands ❒ spoon ❒ fork ❒ other

Does child drink from a regular cup? ____

Toilet/Diapering Habits

Is your child toilet trained? ❒ urination ❒ bowel movement

What is used at home? ❒ Potty chair? ❒ Special seat? ❒ Regular seat?

Word used for urination_____________________ bowel movement_____________________

Is child ever reluctant to use the bathroom? ____________________________________

If not, toilet trained, is there frequent diaper rash? ________________________________

What is used to treat diaper rash? ________________________________

____

Does child wear? ❒ disposable diapers ❒ cloth diapers

Are bowel movements: ❒ regular ❒ irregular how often? ____________________

Is there a problem with: ❒ diarrhea ❒ constipation Any concerns about your child's toilet habits?

Sleeping Habits

Does child nap?

How long does your child nap?

Social Relationships

How would you describe your child?

How would you describe your child in social settings?

Reaction to strangers?

Does your child prefer to play: ❒ alone ❒ in small groups

Favorite toys and activities? ________________________________

Does your child have any fears?__________ Explain:

What comforts your child when he or she is upset?

What is your method for setting limits with your child?

Does child cry easily?__________ When? ________________________________

Under what conditions does child seem worried? ________________________________

Does your child bite?__________ Under what circumstances? ________________________

Does child have temper tantrums?________ When? ________________________________

Home Environment

Does child watch TV? __________ How many hours per day?________________________

What programs? ________________________________

Does child have a room of own?__________ If not, with whom is it shared?________________

Does child spend time with grandparents or other relatives?________________________

How often?________________________________

Experiences with animals? __________ Which ones?________________________

Who reads to your child? __________ How often? ________________________

Favorite books:

____

You and Your Child

Have there been any major changes in the family lately? (New baby, separation or divorce, household move, death)

____

What activities have you enjoyed together recently?

____

What has your child done that has displeased or worried you?

____

What has your child done that has pleased you?

____

What do you, as a family, hope to get out of your experience here at PCCD/Playgoups?

Is there anything else you would like us to know about your child?

Parent/Guardian Signature:_________________________________ **Date:** ______________________

Print Name: ____

The Professional Center
for Child Development

Child's Name ______________________________
Date of Birth ______________________________

EI Community

Parent/Guardian Consent Form

Consent to Apply Sunscreen

- ☐ I give consent for PCCD staff to apply sunscreen that I will provide.
  Please list the brand here: ______________________________
- ☐ I do not give consent.

Consent to Apply Diaper Cream

- ☐ I give consent for PCCD staff to apply diaper cream that I will provide.
  Please list the brand here: ______________________________
- ☐ Diaper cream is not needed for my child.

Consent for Classroom Observations

As part of our program, we often have consultants, specialists, therapists and college or graduate students observe in our classrooms, either to further their understanding of early childhood, or to provide feedback to us about our work with young children. This is one of the ways we learn about and implement best practices in early childhood education at PCCD.

- ☐ I grant permission for my child to be observed in his or her classroom and for our consultants to provide feedback to the teaching and administrative staff.
- ☐ I do not grant permission for my child to be observed in his or her classroom.

Parent/Guardian Signature: ______________________________ **Date:** ______________________________

Print Name: ______________________________

The Professional Center for Child Development

Child's Name ______________________

Date of Birth ______________________

Transportation Plan and Release Authorization

My child will arrive at PCCD and depart from PCCD by parent or another authorized person listed below, unless otherwise noted here: ______________________

I give permission for my child to be released to the following people. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".) Please instruct everyone you authorize us to release your child to that they will need to bring a photo identification each time they pick your child up. ***If child is protected by a restraining order, please submit order to PCCD.***

Release Authorizations

I authorize PCCD to release my child to the following people:

❒ No One

Name: ______________________

Address: ______________________

Alternate Telephone #: ______________________

Relationship: ______________________

Telephone #: ______________________

Alternate Telephone #: ______________________

Name: ______________________

Address: ______________________

Alternate Telephone #: ______________________

Relationship: ______________________

Telephone #: ______________________

Alternate Telephone #: ______________________

Mass Health (MH) Member: ______________________

Child's Weight: ______________________

Parent/Caregiver Name: ______________________

Parent/Caregiver Name: ______________________

Provider Name: ______________________

Address (# & Street): ______________________

City, Zip Code: ______________________

Contact Person: ______________________

Telephone #: ______________________

Parent/Guardian Signature: ______________________ **Date:** ______________________

Print Name: ______________________

The Professional Center for Child Development

Child's Name ______________________________

Date of Birth ______________________________

E-mail Communication Consent Form

Please use this form to indicate any changes in your email preferences. Email address(es) provided on this form will supersede those currently in our databases.

Please send invoices to:

1st Email Address: ______________________________

2nd Email Address: ______________________________

IMPORTANT: Please note that invoices will come from the email address quickbooks@notification.intuit.com. We recommend that you add this email address to your "safe senders list" to ensure that monthly invoices from PCCD do not end up in your spam folder.

Parent Signature: ______________________________ Date: __________

The Professional Center for Child Development

Child's Name ______________________
Date of Birth ______________________

Photo Release Form

Photography, Website & Application Consent Form

I authorize PCCD to have, use, publish and reproduce images, slides, or videotape of my child for its records and for displays of our classroom activities inside the classrooms and in our school.

❒ I do authorize such use. ❒ I do not authorize such use.

I authorize PCCD to use images of my child for our public relations efforts, including brochures, marketing materials, slideshows, videos, and on our website (children will not be identified)

❒ I do authorize such use. ❒ I do not authorize such use.

I authorize PCCD to post images of my child on a classroom web site or application, with access granted only to parents of children in that classroom, teachers, and PCCD administrators.

❒ I do authorize such use. ❒ I do not authorize such use.

Parent/Guardian Signature:____________________ **Date:** _________________
Print Name: ____

The Professional Center for Child Development

Child's Name ______________________

Date of Birth ______________________

Medication Consent Form

(A separate form must be filled out for each individual medication.)

Name of Medication: ______________________

State regulations require that the medication brand name listed must exactly match the name on the packaging. For example, if the name of the medication listed on this form is Benadryl®, you may not bring in a generic substitute.

Please check one of the following

- ☐ Prescription *(requires parent and health care practitioner signature)*
- ☐ Oral/Non-prescription *(requires parent and health care practitioner signature)*
- ☐ Topical Non-prescription (applied to open wound/ broken skin) *(requires parent and health care practitioner signature)*
- ☐ Topical, Non-prescription NOT applied to open wound or broken skin *(requires parent signature only)*

Please check one

- ☐ 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

Dosage: ______________________

Please check one

- ☐ Date(s) medication to be given: from______________to______________

  Times medication to be given: ______________________
- ☐ Unanticipated Non-prescription for mild symptoms (administer as needed)

Reasons for medication: ______________________

Possible side effects: ______________________

Directions for storage: ______________________

______________________ **Date:** ______________

Child's Health Care Practitioner Signature

______________________ **Phone:** ______________

Print Name (Child's Health Care Practitioner)

I,______________________(parent or guardian), authorize educator(s) at PCCD to administer medication to my child as indicated above and to contact my child's Health Care Practitioner if needed.

______________________ **Date:** ______________

Parent/Guardian Signature

Massachusetts Asthma Action Plan

Name:		Date:
Birth Date:	Doctor/Nurse Name:	Doctor/Nurse Phone #:
Patient Goal:	Parent/Guardian Name & Phone #:	
Important! Avoid things that make your asthma worse:		

Personal Best Peak Flow: ______________________

The colors of a traffic light will help you use your asthma medicine.

GREEN means Go Zone!
Use controller medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

GO — You're doing well!

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Use these daily controller medicines

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CAUTION — Slow Down!

You have *any* of these:

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Coughing, wheezing or trouble breathing at night

Continue with green zone medicine and add:

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR DOCTOR/NURSE: ______________________

DANGER — Get Help!

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Take these medicines and call your doctor now.

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature ______________________ **DATE** ____________

I give permission to the school nurse, my child's doctor/NP/PA or ______________________ to share information about my child's asthma.

Parent/Guardian Signature ______________________ **DATE** ____________

— SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION —

ADAPTED FROM NIH PUBLICATION (7/20/01)

Make copies of this plan for: patient/parent, provider, and school.

— IMPORTANT INSTRUCTIONS: SEPARATE THIS PAGE BEFORE WRITING —

Consent for administration of medication in school:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication asprescribed on the reverse side of page.

Parent/Guardian Signature ________________________________ DATE ______________________

Authorization for student self-administration of medication in school:

I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02118. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

COMMENTS/SPECIAL INSTRUCTIONS:

SIGNATURES	DATE
Student's Doctor/Nurse ________________________________	______________________
Parent/Guardian ________________________________	______________________
Medication administration plan completed ________________________________	______________________
School Nurse's approval ________________________________ SIGNATURE	______________________

Listed below are regulations governing the self-administration of prescription medication 105 CMR 210.006

(A) Consistent with school policy, students may self-administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 2100.000, "self-administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

(B) The school nurse may permit self-medication of prescription medication by a student provided that the following requirements are met:

(1) the student, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self-administered;

(2) the school nurse, as appropriate, develops a medication administration plan (105 CMR 210.005 (E)) which contains only those elements necessary to ensure safe self-administration of prescription medication;

(3) the school nurse evaluates the student's health status and abilities and deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of prescription medication;

(4) the school nurse is reasonably assured that the student is able to identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self-administration protocols;

(5) there is written authorization from the student's parent or guardian that the student may self-medicate, unless the student has consented to treatment under M.G.L. c. 112,§ 12F or other authority permitting the student to consent to medical treatment without parental permission;

(6) if requested by the school nurse, the licensed prescriber provides a written order for self-administration;

(7) the student follows a procedure for documentation of self-administration of prescription medication;

(8) the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;

(9) the school nurse develops and implements a plan to monitor the student's self-administration, based on the student's abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the prescription medication;

(10) with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ____________

Allergy to: ______________________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________________

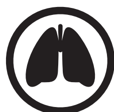
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

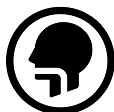
FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

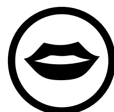


LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

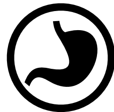


THROAT
Tight or hoarse throat, trouble breathing or swallowing

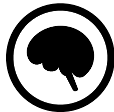


MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



OTHER
Feeling something bad is about to happen, anxiety, confusion

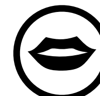
OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

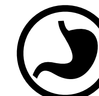
MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing



MOUTH
Itchy mouth

SKIN
A few hives, mild itch



GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

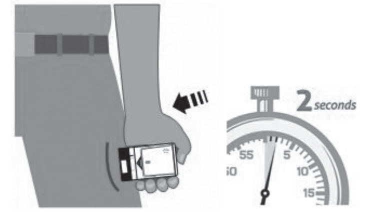
____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

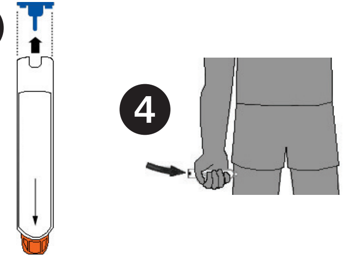
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



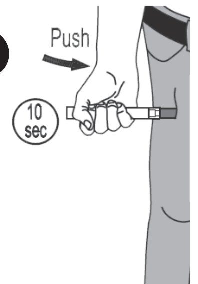
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________________

DOCTOR: ______________________ PHONE: ____________

PARENT/GUARDIAN: ______________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________ PHONE: ____________

NAME/RELATIONSHIP: ______________________ PHONE: ____________

NAME/RELATIONSHIP: ______________________ PHONE: ____________

The Professional Center
for Child Development

Child's Name ______________________

Date of Birth ______________________

Individual Health Care Plan

Name of Chronic condition: ______________________

Symptoms: ______________________

____

Medical treatment that may be necessary while the child is at school (be as specific as possible):

____

____

Describe any potential side effects of the treatment:

____

____

Describe the potential consequences to the child's health if the treatment is not administered:

____

____

Educators must complete training that specifically addresses the child's medical condition, medication and other treatment needs. Describe who may train the designated staff:

- ❒ The health care practitioner approving this plan
- ❒ The parent
- ❒ PCCD Health Care Nurse

Name of educators that received training addressing the medical condition:

____

Health Care Practitioner Signature: ______________ Date: ______________

Please Print Name: ______________ Phone: ______________

Parent/Guardian Signature: ______________ Date: ______________

Print Name: ______________________

Please attach any further documentation, if needed, to this plan.

Please note*: State regulations require that we also have a Medication Consent Form, signed by your child's health care practitioner and by a parent, to administer prescription OR non-prescription medication. Non-prescription, topical medication not applied to wounds or broken skin requires only a parent signature.*