Individualized Health Care Plan

Child's Name:_____DOB:_____

Address:_____

Diagnosis:_____

Parents/guardian Name:_____

Emergency Number:_____

Primary Care Provider:_____Telephone:_____

ALLERGIES:_____

Plan of Care:

Signs/symptoms:

Actions to take:

Restrictions of Activities:

Individualized Health Care Plan

Signature Page

_____

(Signature of Health Care Provider)(Date)

_____

(Signature of Parents or guardian)(Date)

_____

(Reviewed by Child Care Health Consultant)(Date)

SIGNATURES OF ALL CHILD CARE STAFF CARING FOR THIS CHILD