



Arlington Heights Nursery School

*Established 1965*

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
- AHNS Health Care Consultant

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, in order to administer prescription OR non-prescription medication. Non-prescription, topical medication not applied to wounds or broken skin requires only a parent signature.