Old Colony Y

Individual Health Care Plan & Medication Consent Form 606 CMR 7.11(2) (b)

Name of child:	D.O.B.:

Name and description of chronic health care condition/Reason for medication: (Individual forms are required for each chronic health care condition/Reason for medication if more than one)

Symptoms:

Medical treatment necessary while at the program (include medication name, dosage, dates and times needed):

Medication Name: _____ **ONLY 1 medication per form – each medication needs a separate form**

Dosage: _____ Dates Needed: From _____ to _____ Times Needed: _____

Check all that apply...

Plan was created by:
_ Parent/Guardian
_ Doctor or Licensed Practitioner
_ Program's Health Care Consultant
_ Other: _____

Plan is maintained by:
_ Director/Asst. Director
_ Site Coordinator
_ Old Colony Y Staff/Educators
_ Other: _____

Above Listed Medication: Please ✓ all of the following that apply

___ Prescription ___Oral/Non-Prescription ___ Unanticipated Non-Prescription for mild symptoms
___ Topical Non-Prescription (applied to open wound/ broken skin) ___ Topical Non-Prescription (NOT 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 Old Colony Y staff to give this medication to my child in accordance with this individual health care plan & medication consent form

Potential side effects of treatment/medication:

Potential consequences if treatment/medication is not administered:

Directions for storage:

Name and phone number of the prescribing health care practitioner:

Name of educators that received training addressing the medical condition:
Any Old Colony Y staff who have taken the "5 Rights of Medication" training, have current First Aid Certification, and have been trained by someone listed below.

Person who trained the educator (circle one)
Child's Health Care Practitioner, child's parent, Old Colony Y's Health Care Consultant, Certified First Aid Instructor, School Nurse

REQUIRED AUTHORIZATIONS:

The undersigned authorizes Old Colony Y staff to receive training relative to the child's IHCP by the child's parent, Old Colony Y's health care consultant or another representative selected by the parent and for Old Colony Y staff to administer the above medication as indicated while at program.

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

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

**If the child has asthma/food allergies please attach copy of current Asthma/Food Allergy Action Plan to this form*