

Name of child: _____

Project Learn Childcare

Date: _____

Individual Health Care Plan (IHCP)

*PLEASE NOTE – the PARENT/GUARDIAN MUST inform the program IMMEDIATELY if there are ANY changes/adjustments to this plan. The plan is only valid for one year.

- Please all that apply. This plan is created by: Parent Doctor or health care practitioner Other *please state who:

Name & description of medical condition	Symptoms	Medical treatment necessary while at the program	Potential side effects of treatment	Potential consequences if not treated

Name of Licensed Health Care Practitioner (please print) _____

Licensed Health Care Practitioner signature _____ Date: _____

Parental/Guardian signature _____ Date: _____

-----OFFICE USE ONLY-----

This plan is maintained by:
_____ Childcare Director _____ Other – please state who _____

Names of educators who received training addressing this medical condition _____

Person who trained the educators _____ Date _____