

MEDICAL ACTION CARE PLAN

Child's Name: _____ Date of Birth ____/____/____

Parent / Guardian Name: _____

Emergency Phone Numbers: Parent/Guardian: _____ If no answer call: _____
See emergency contact information for alternate contacts if parents are unavailable

Primary Health Care Provider: _____

Phone #: _____

To be completed by the Healthcare Provider/Physician

DIAGNOSIS: 1. _____ 2. _____

Administer the Emergency Medication listed below when child has the following medical emergency:

Emergency Medication	Schedule (when)	Dose (How much)	Route (How)	Possible Side Effects
	*MUST match prescription label	*MUST match prescription label		

CALL PARENT'S FOR: _____

GET MEDICAL ATTENTION FOR: _____

CALL 911 FOR: _____

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state and federal laws and regulations.

Health Care Provider Signature: _____

Date: _____

To be completed by the Parent/Guardian

I have developed this health plan in partnership with my child’s healthcare provider and Head Start staff. I will communicate any changes in my child’s identified health condition or treatment to Head Start staff as changes occur.

Effective _____ Expires _____ This plan will be reviewed and updated annually.

As the parent/legal guardian of _____ (Child’s Name), I _____ (Parent/Guardian Name) give my Permission for OVEC Staff to administer the Emergency Action Plan including the administration of Medication as stated in this plan and post information under the classroom Health Alert. I further release OVEC and its employees from any claims or liability connected with its reliance on this permission

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date: _____

To be completed by Staff after being trained

By signature, staff acknowledges education by parent or guardian on condition(s) and requirement of emergency care and/or medication if needed.

(All staff in center must be trained):

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____