



Arlington Heights Nursery School
Established 1965

Child's Name _____
Date of Birth _____

Individual Health Care Plan 2010 - 2011

Child's Name _____ **Date of Birth** _____

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

Health Care Practitioner's Signature _____ Date _____

Please Print Name _____

Phone Number _____

Parent Signature _____ Date _____

Please Print Name _____

Please attach any further documentation, if needed, to this plan.

Please note that 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.