

Child Medical Action Plan

To ensure the health and safety of your child, it is vital that any person involved in your child's care be aware of your child's special health needs, medication, or needs in case of a health care emergency, and the specific actions to take. Complete and submit the following Medical Action Plan if your child has healthcare needs that may require specialized health services (e.g. seizures, diabetes, etc.). **(Asthma and Allergies have action plans specific to those conditions.)**

TO BE COMPLETED BY CHILD'S HEALTHCARE PROVIDER:

DIAGNOSIS (ES):

MEDICATION (S): List ALL medications the child may take related to the above conditions (attach additional sheets as necessary). A parent/guardian must submit a Medication Administration Form for any additional, unrelated medication to be administered at childcare. Doses of medication administered at home must be documented in the Tadpoles app prior to a child's arrival at the Program each morning.

Medication Name: _____			<input type="checkbox"/> Daily medication taken at childcare	<input type="checkbox"/> Daily medication taken at home	<input type="checkbox"/> Emergency medication
Dosage: _____	Time/frequency: _____	Route: _____			
Special Instructions: _____	Side effects: _____	Reason Prescribed: _____			

Medication Name: _____			<input type="checkbox"/> Daily medication taken at childcare	<input type="checkbox"/> Daily medication taken at home	<input type="checkbox"/> Emergency medication
Dosage: _____	Time/frequency: _____	Route: _____			
Special Instructions: _____	Side effects: _____	Reason Prescribed: _____			

MEDICAL ACCOMMODATION (S): Describe any reasonable accommodation(s) related to the above diagnosis(es) the Program can implement to encourage the child's full and active participation.

Diet or Feeding:
Classroom Activities:
Naptime/Sleeping:
Outdoors:
Toileting:
Other/Comments:

EQUIPMENT/MEDICAL SUPPLIES

1.
2.
3.

EMERGENCY CARE

Call parents/guardians if the following symptoms are present:

Call 911 (emergency medical services) if the following symptoms are present, and contact parents/guardians:

Take these measures while waiting for parents/guardians or medical help to arrive:

Healthcare Provider completing this form:

_____	_____
(Provider Name)	(Provider Phone)
_____	_____
(Provider Signature)	(Signature Date)

TO BE COMPLETED BY CHILD'S PARENT/GUARDIAN:

Parent/Guardian Name(s):	Phone:	
Child's PCP:	Phone:	
Specialist:	Type:	Phone:
Specialist:	Type:	Phone:

Parent/Guardian Authorization:

Does your child have a known allergy/reaction to any medication listed on this form? Yes No

Have the medications on this form ever been administered to your child? Yes No

Comment:

I acknowledge that I am required to document in the Tadpoles app any doses of medication my child receives before their arrival at the Program each morning.

I authorize Village Early Childhood Center, including it's Administrators, Staff, Volunteers, or other agents to provide or arrange for medical care in accordance with this Medical Action Plan. I release and discharge Village Early Childhood Center, it's Administrators, Staff, Volunteers, or other agents from all claims and liability for any loss or injury that may occur in the future as a result of care provided under this authorization and release. I further agree to reimburse, indemnify, and hold Village Early Childhood Center harmless from any and all costs, claims, and liabilities associated with providing or arranging medical care for my child.

I hereby give consent for the providers listed above to communicate with Village Early Childhood Center to discuss any of the information contained in this action plan.

_____	_____	_____
(Parent/Guardian Name)	(Parent/Guardian Signature)	(Date)