**Illness/Injury Medical Care Plan**

**Dear Medical Practitioner:**

**This form is required in order for us to determine whether or not to accept an ill or injured child back into childcare. Because we have young infants and children with compromised immune systems in our care, it is urgent that you fill this form out as thoroughly as possible, and then we will make the decision concerning when the child may return to our group, so no doctor’s note will be necessary on your part. Our parents are aware of this requirement and understand they may need to sign a release of information. We are only concerned with this visit, not a past medical history unless it pertains to this illness.**

**Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This illness can be spread by the following (check all that apply):**

**\_\_\_\_Direct physical contact \_\_\_\_Indirect surface contact**

**\_\_\_\_ Respiratory Droplets \_\_\_\_Airborne particles**

**\_\_\_\_Food/Waterborne \_\_\_\_Vector borne**

**\_\_\_\_Saliva \_\_\_\_Sores weeping**

**\_\_\_\_Fecal/Urine \_\_\_\_This is an injury – Not contagious**

**Temperature when seen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication prescribed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If child is being seen for a head injury, what is the observation period?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We appreciate you filling out this form. By doing so we are able to make educated decisions about exclusion based on complete information from a healthcare professional. In addition it removes liability from your shoulders and places it on ours. We will not accept a child back into care without this form completed. You may seal in an envelope if you wish.**

**Notes for us:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD / NP / RN / \_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone or email for contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**