Child Health Plan and Provider Orders - Skin Condition

Center: _____ ☐Early Head Start ☐Head Start ☐ECEAP

Child's Name: _____ DOB: _____ Gender: M / F

Parent/Guardian: _____ Phone: (H) _____ (C) _____

My child has the following skin condition: (check all that apply)

☐Eczema ☐Atopic Dermatitis ☐Other: _____

Identify areas affected: _____

_____

What makes the condition worse? (check all that apply)

☐Dry skin ☐Stress ☐Allergies ☐Excessive heat/sweating
☐Soaps/detergents/lotions ☐Pollen/dust/mold ☐Wet skin/water play
☐Other: _____

Plan/Accomodations: _____

_____

_____

_____

_____

_____

Is medication(s) taken at home? ☐Yes ☐No (list): _____
Is medication(s) needed while at school? ☐Yes ☐No (If YES, refer to provider order's)
Is medication(s) needed during transport to/from school? ☐Yes ☐No

Child's Name: _____ DOB: _____ Gender: M / F

☐No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:
Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name 2) Symptoms for medication use

3) Dose 4) Frequency & Length of time between doses 5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: _____ **AND** End date: _____

Health Care Provider's Signature Date

Print name Phone # Fax #

Parent/Guardian Signature Date

Interpreter Signature Date

Nurse Consultant Signature Date

ITE/Teacher Date ITP/Assistant Date FA/FE/FSS/HV Date Dir/C Coor Date