

Child Health Plan and Provider Orders Form - 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/Accommodations: _____

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

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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

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant

Date

ITE/Teacher Date

ITP/Assistant Date

FA/FE/FSF/HV Date

Dir/C Coor Date