Child Health Plan and Provider Orders - Other Health Conditions

Center: ______________________ ☐Early Head Start ☐Head Start ☐ECEAP

Child's Name: ______________________ DOB: ____________ Gender: M / F

Parent/Guardian: ______________________ Phone: (H) ____________ (C) ____________

Health Condition: ____

Parent/Provider Input: ____

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Child-Specific Emergencies	
If you see this:	Do this:

Any program activities where accommodations are needed? (Class, outdoor activities, field trips, nutrition).

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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