Child Health Plan and Provider Orders Form - 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

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant   Date

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