Commonwealth of Massachusetts
Department of Early Education and Care
606 CMR 7.11(3)

Place Child's Picture Here

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Child's Name: _____ Date: _____

Child Date of Birth: _____ Grade: _____

Name of Chronic Health Care Condition:
Symptoms:
Medical Treatment Necessary While at the Program (including name of medication, dosage, dates/time to use):
Potential Side Effects of Treatment:
Potential Consequences if Treatment is Not Administered:

Individual Health Care Plan Training

Name of Educators that Received Training Addressing the Medical Condition: __Tobin Staff____

Person Who Trained the Educator (Child's Health Care Practitioner, Child's Parent, Program's Health Care Consultant):

_____

Plan was created by:
- __ Parent
- __ Doctor or Licensed Practitioner
- __ Program's Health Care Consultant
- __ Other: _____

Plan is maintained by:
- __ Director
- __ Assistant Director
- __ Child's Educator
- __ Other: _____

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

CHILD CARE ASTHMA/ALLERGY ACTION CARD

Child's Name_____
ALLERGY TO:_____
ASTHMATIC: YES* NO (* Higher risk for severe reaction) _____

Emergency Contact #1
Name:_____ Relationship: _____
Phone 1: _____ Phone 2:_____

Emergency Contact #2
Name:_____ Relationship:_____
Phone 1: _____ Phone 2:_____

Physician child sees for Asthma/Allergies: _____ Phone:_____
Other Physician: _____ Phone: _____

ASTHMA/ALLERGY MANAGEMENT PLAN

Identity Asthma/Allergy Triggers

☐ Animals	☐ Bee/Insect Sting	☐ Chalk Dust	☐ Change in Temperature
☐ Dust Mites	☐ Exercise	☐ Latex	☐ Molds
☐ Pollens	☐ Respiratory Infections	☐ Smoke	☐ Strong Odors

Food: _____
Other: _____

ASTHMA EMERGENCY PLAN: *Emergency action is necessary when child has symptoms such as:*

FOOD ALLERGY SYMPTOMS AND TREATMENT

Symptoms		Give Checked Medication:
If a food allergen has been ingested, but no symptoms:		___ Epinephrine ___ Antihistamine
MOUTH	Itching, tingling, or swelling of lips, tongue, mouth	___ Epinephrine ___ Antihistamine
SKIN	Hives, itchy rash, swelling of the face or extremities	___ Epinephrine ___ Antihistamine
GUT	Nausea, abdominal cramps, vomiting, diarrhea	___ Epinephrine ___ Antihistamine
*THROAT	Tightening of throat, hoarseness, hacking cough	___ Epinephrine ___ Antihistamine
*LUNG	Shortness of breath, repetitive coughing, wheezing	___ Epinephrine ___ Antihistamine
*HEART	Weak pulse, low blood pressure, fainting, pale, blueness	___ Epinephrine ___ Antihistamine
*OTHER_____		___ Epinephrine ___ Antihistamine
If reaction is progressing (several of the above areas affected), give		___ Epinephrine ___ Antihistamine

Potentially life-threatening. The severity of symptoms can quickly change.

MEDICATION INSTRUCTIONS

Medication Scenario	Name of Medication	Dose/Route	When to Use
DAILY Medication for Asthma/Allergies			
EMERGENCY Asthma Medication			
EMERGENCY Allergy Medication			