The Center For The Development of Children
30 Springdale Ave.
PO Box 279
Dover, MA 02030

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Individual Health Care Plan Form

Attach Picture here

Name of child:	Date:
Name of chronic health care condition:	
Description of chronic health care condition	
Symptoms:	
Medical treatment necessary while at the program: (Include all medications, doses and times if necessary)	
Potential side effect of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	

**The parent or the program's Health Care Consultant may train the staff in the implementation of this child's IHCP and the program may administer all medication listed above (prescription and over the counter) in accordance to this child's IHCP.

Name of licensed Health Care Practitioner (please print)_____

Licensed Health Care Practitioner authorization_____ Date_____

Parent/Guardian consent_____ Date_____