ORIGINAL — Medical File 21.	Date
cc: Med. Box	
cc: Child Care Health Consultant	
cc: Primary Health Care Provider	
Cc: Parent	
cc:	

date updated 8/12/03

PROGRAM NAME
INDIVIDUAL HEALTH AND EMERGENCY MANAGEMENT PLANS

NAME: 1. **DATE PLAN WRITTEN:** 2.

DOB: 3. **REVISION DATES:** 4.

PARENT(S) NAMES: 5. **HOME PHONE:** 6.

MOTHER Work #: 7. **FATHER Work #:** 8.

PRIMARY CARE DOCTOR: 9. **PHONE #:** 10.

SPECIALISTS: 11. **PHONE #** 12.

Medical Diagnosis: 13.

Health History (past and present): 14.

Allergies: 15.

Medications: 16.

TX/PREVENTATIVE STEPS	SYMPTOMS OF EMERGENCY	EMERGENCY MEASURES
17.	18.	19.

PERSONS RESPONSIBLE FOR PROCEDURE/MEDICATION: 20.			
Director		Parents	
Teacher			
Assistant Teacher			
Assistant Director			

Parent's Signature: 22. **Date:**

Physician's Signature: 23. **Date:**

How to fill out INDIVIDUAL HEALTH AND EMERGENCY MANAGEMENT PLANS

Number	Description	"How To"
1.	Name	Enter whole name of child – enter nickname here in quotes
2.	Date Plan Written	Enter the date you write the plan – so you can reference how current the plan is
3.	DOB	Enter the child's birth date
4.	Revision Dates	Enter any dates you make changes to the plan – again so you know you have the most current information
5.	Parent(s) Names	Enter the names of parents or guardians
6.	Home Phone	Enter the home phone number of the family
7.	Mother Work #	Enter the number for the mother's work – this category can easily be changed to suit individual needs (i.e. "grandmother" or "cell-phone #")
8.	Father Work #	Enter the number for the father's work – see above
9.	Primary Care Doctor	Enter the name of the child's physician or primary health care provider as well as the organization. (i.e.: Dr. Edwin Clonts, Metropolitan Pediatrics)
10.	Phone #	Enter the Dr.'s phone number
11.	Specialists	Enter the name and organization of any specialists the child sees
12.	Phone #	Enter the phone number for the specialists
13.	Medical Diagnosis	Enter a brief description of the child's medical diagnosis. (i.e. : Cerebral palsy, microcephalcey, and seizure disorder)
14.	Health History (past and present)	Enter a brief description of pertinent health information including both past and present information. (i.e. "asthma since infancy; coughing and wheezing. Child experiences increase in symptoms during winter and spring. Usually takes Albuteral every four hours during this time.")
15.	Allergies	Enter any known allergies the child has
16.	Medications	Enter any medication the child takes including dosage and frequency.
17.	Tx/ Preventative Steps	Information here should address the ways to prevent an emergency situation such as environmental changes or procedures
18.	Symptoms of Emergency	Enter information here that the ER plan is designed to address. The Symptoms of Emergency should include indicators of distress, situations that require immediate attention, or items that one should be aware of.
19.	Emergency Measures	Enter information here on what to do when an emergency situation occurs such as medical steps to take, people to call, step by step instructions on care provided
20.	Persons Responsible for Procedures/Medications	This category is for names of school or child care center persons involved in the child's care. This list should serve as a reminder list of who to inform of emergency plan.
21.	Originals/copies	This category serves as a reminder of who needs a copy of this plan. Fill in appropriate places where file copies are kept.
22.	Parent's signature / date	Parents should sign and date a finished plan to indicate their knowledge and approval of emergency procedures.
23.	Physician's Signature/Date	Physicians or primary health care provider should sign and date a finished plan to indicate their knowledge and approval of emergency procedures.

ORIGINAL — Medical File	Date
cc: Med. Box	
cc: Child Care Health Consultant	
cc: Primary Health Care Provider	
Cc: Parent	
cc:	

PROGRAM NAME
INDIVIDUAL HEALTH AND EMERGENCY MANAGEMENT PLANS

NAME: _____ **DATE PLAN WRITTEN:** _____

DOB: _____ **REVISION DATES:** _____

PARENT(S) NAMES: _____ **HOME PHONE:** _____

MOTHER Work #: _____ **FATHER Work #:** _____

PRIMARY CARE DOCTOR: _____ **PHONE #:** _____

SPECIALISTS: _____ **PHONE #** _____

Medical Diagnosis: _____

Health History (past and present): _____

Allergies: _____

Medications: _____

TX/PREVENTATIVE STEPS	SYMPTOMS OF EMERGENCY	EMERGENCY MEASURES

PERSONS RESPONSIBLE FOR PROCEDURE/MEDICATION:

Director	_____	Parents	_____
Teacher	_____		_____
Assistant Teacher	_____		_____
Assistant Director	_____		_____

Parent's Signature: _____ **Date**: _____

Physician's Signature: _____ **Date:** _____