This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

# Individual Care Plan Request Form

**Child's name:** _____

**Child's date of birth:** _____

**Early Learning or Child Care Program Director:** _____

**Early Learning or Child Care Program:** _____

**Mailing Address:** _____

**Phone Number:** _____

**Fax Number:** _____

**Healthcare Provider:** The child listed above attends our program. This packet includes forms to help meet our licensing standards (WAC 110-300-0215 and 110-300-0300). **Please complete pages 2-7**. These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

**Parent or Guardian Name (Printed):** _____

**Parent or Guardian Signature:** _____

**Date:** _____

**Parent or Guardian Phone Number:** _____

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

# Individual Care Plan

**Healthcare Provider:** If the child has been diagnosed with allergies, asthma, diabetes, food intolerance, or seizures, please contact the program listed on page 1 to request the appropriate care plan packet.

**Child's name:** _____

**Child's date of birth:** _____

**Medical or behavioral condition(s)** (if known)**:** _____

_____

## Emergency Response Plan

| |
|---|
| **Call parent or guardian if the following medical or behavioral symptoms are present:** |
| **Call 911 Emergency Medical Services (EMS) and emergency contacts if the following symptoms are present:** |
| **Steps to take while waiting for EMS to arrive:** |
| **Additional healthcare provider notes:** |

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

# Specific Care and Treatment Instructions

**Child's name:** _____

| |
|---|
| **Dietary or Feeding Modifications** (not related to food allergy or food intolerance)**:** |
| **Environmental and Activity Modifications** (for example: classroom layout, diapering, toileting, naptime or sleeping, outdoor play)**:** |
| **Behavioral Modifications** (for example: redirection techniques, activity transition needs)**:** |
| **Special Equipment and Medical Supplies** (communication equipment, chairs, sensory toys, durable medical equipment [DME])**:** |
| **Triggers or Stimuli to Avoid:** |
| **Suggested Skills or Training for Teachers** (for example: pediatric first aid, CPR for special health care needs)**:** |

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

# Care Schedule

**Child's name:** _____

| Time | Care Needs |
|---|---|
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This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

# Medication Authorization Form

**Early Learning or Child Care Program Staff:** Medications must be given as directed by the medication label or packaging. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form. Each medication must have its own Medication Authorization Form.

**Child's name:** _____

**Child's date of birth:** _____

**Name of medication:** _____

**Reason for medication:** _____

**Possible side effects of medication:** _____

**Medication expiration date:** _____

**When to give the medication** (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication): _____

**How much medication to give** (must include dose of medication): _____

**How long to give the medication** (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year): _____

**How to give the medication** (for example: by mouth [oral], on skin [topical], injection, etc.): _____

**Medication requires special storage:** ☐Yes ☐No

**If yes, specify** (for example: refrigerate; keep away from light; etc.): _____

**Additional instructions:** _____

**Healthcare Provider Name** (Printed): _____

**Healthcare Provider Signature:** _____

**Healthcare Provider Phone Number:** _____

**Date:** _____

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

# 3-Day Critical Medication Authorization Form

**Healthcare Provider and Parent or Guardian:** In the event the child needs to remain at the program past usual hours, a 3-day supply of Critical Medication(s) must be kept at the program. This life-sustaining medication is usually given when the child is not in care. Examples may include certain diabetes, seizure, or asthma medications. A new 3-Day Critical Medication Authorization Form should be completed if there are changes to the medication or child's health condition.

**Program Staff:** This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each 3-Day Critical Medication must have its own 3-Day Critical Medication Authorization Form. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form.

**Child's name:** _____

**Child's date of birth:** _____

**Name of medication:** _____

**Reason for medication:** _____

**Possible side effects of medication:** _____

**Medication expiration date:** _____

**When to give medication** (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

**How much medication to give** (must include dose of medication)**:** _____

**How long to give medication** (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

**How to give the medication** (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

# 3-Day Critical Medication Authorization Form (Continued)

**Medication requires special storage:** ☐ Yes ☐ No

**If yes, specify** (for example: refrigerate; keep away from light; etc.)**:**_____

**Additional instructions:** _____

**Parent or Guardian:** By signing below, I give the program permission to give this medication to my child as described on this 3-Day Critical Medication Authorization Form.

**Parent or Guardian Name** (Printed)**:** _____

**Parent or Guardian Signature:** _____

**Date:** _____

**Healthcare Provider:** By signing below, I acknowledge that this child requires a 3-Day supply of Critical Medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

**Healthcare Provider Name** (Printed): _____

**Healthcare Provider Signature:** _____

**Healthcare Provider Phone Number:** _____

**Date:** _____

Public Health
Seattle & King County

# Additional Requirements for Care Plans

**Program Staff and Parent or Guardian:** The WAC requires a parent**,** guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

| Employee Training Record | | | | |
|---|---|---|---|---|
| **Date of Training** | **Employee Name (Printed)** | **Employee Signature** | **Trainer Name (Printed)** | **Trainer Signature** |
| | | | | |
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**Additional Parent or Guardian Notes:**

**Program Staff and Parent or Guardian:** The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

**Parent or Guardian Name** (Printed)**:** _____

**Parent or Guardian Signature:** _____

**Date:** _____

This page to be completed by:
Parent or Guardian

Public Health
Seattle & King County

# Visiting Health Professionals

**Child's name:** _____

**Parent or Guardian:** The WAC requires a child's parent or guardian to provide written consent to allow visiting health professionals (for example: speech or occupational therapist) to provide services while the child is at the program. Please complete the following information for any visiting health professionals or agencies for your child.

**Care Team Member #1**

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

**Care Team Member #2**

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

**Care Team Member #3**

Name or Agency: _____

Professional Role or Services: _____

Phone Number: _____

By signing below, I give these visiting health professionals or agencies permission to provide services to my child while at the program.

**Parent or Guardian Name** (Printed): _____

**Parent or Guardian Signature:** _____

**Date:** _____

This page to be completed by:
Parent or Guardian

Public Health
Seattle & King County

# Emergency Contact Information

**Child's name:** _____

**Parent or Guardian:** If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

**Emergency Contact #1**

Name: _____

Relationship to Child: _____

Phone Number: _____

**Emergency Contact #2**

Name: _____

Relationship to Child: _____

Phone Number: _____

**Emergency Contact #3**

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by:
Program Staff

Public Health
Seattle & King County

# Medication Log

**Program Staff:** Please print a Medication Log for each medication (including any 3-Day Critical Medication).

**Child's name:** _____

**Child's date of birth:** _____

**Name of medication:** _____

| Date | Time | Dose | Person Giving Medication (*Initials) | Reason Medication Was Not Given | Observed Side Effects |
|---|---|---|---|---|---|
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| Initials* | Printed Name and Signature of Person Giving Medications |
|---|---|
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This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

# Controlled Substance Medication Log

**Program Staff:** Some medications are "controlled substances," meaning the medication is regulated by the federal government due to potential for abuse. Examples include certain medications for pain, ADHD, and seizures. Each controlled substance must have its own Controlled Substance Medication Log. Controlled substances must be stored in a locked container or cabinet.

**Child's name:** _____

**Child's date of birth:** _____

**Name of medication:** _____

**Amount or quantity of medication received by program:** _____

**Signature of program director:** _____

**Signature of parent or guardian:** _____

**Amount or quantity of medication returned to parent or guardian:** _____

**Signature of program director:** _____

**Signature of parent or guardian:** _____

| Date | Time | Dose | Starting Amount or Quantity | Amount or Quantity Given | Staff 1 *Initials | Staff 2 *Initials (Witness) |
|---|---|---|---|---|---|---|
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This page to be completed by:
Program Staff and Parent or Guardian

| Date | Time | Dose | Starting Amount or Quantity | Amount or Quantity Given | Staff 1 *Initials | Staff 2 *Initials (Witness) |
|---|---|---|---|---|---|---|
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***Initials and signatures of individuals giving the medication and witnessing the medication administration:**

| Initials | Printed Name and Signature of Staff 1 and Staff 2 |
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