

Individualized Health Care Plan (IHCP)

Child Care Program: _____ **Date of plan:** _____

Child's Name: _____ **DOB:** _____ **Room** _____ **Teacher (s)** _____

Address: _____ **Parents' daytime contact phone numbers:**
Mother/Guardian: Name: _____

Primary Language: Child: _____ Family: _____ (H) _____ (W) _____ (cell) _____

Diagnosis: _____ Father/Other: Name: _____
(H) _____ (W) _____ (cell) _____

Allergies: _____ Emergency Contact: Name: _____

Preferred Hospital: _____ (H) _____ (W) _____ (cell) _____

Primary Care Provider: _____ Phone: _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

Other health care providers (specialists): _____ Phone numbers: _____

1. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

2. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

3. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

4. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

Other Consultants/Specialists (e.g. ed, mental health, soc serv) Phone numbers: _____

1. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

2. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

3. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

4. _____

Permission to contact: YES/ NO Parent/Guardian signature: YES/ NO

Special needs and adaptations:

Nutrition/diet: _____

Communication/language: _____

Fine Motor: _____

Gross Motor: _____

Social-Emotional: _____

Sleep: _____

Elimination: _____

Transportation: _____

Restrictions/Modifications (if any):

Classroom: _____

Outdoor Play _____

Field Trips: _____

Support Services/Agencies (IEP on file): _____

Medications (Refer to medication authorization forms and policies)

Name

Amount

When to use

In child care/ kindergarten:

1. _____

2. _____

3. _____

4. _____

At home:

1. _____

2. _____

3. _____

4. _____

Plan of Care:

<i>Signs or symptoms</i>	<i>Actions to take</i>

Special equipment and instructions/treatments: _____

Teacher Training (Include date of training, name of trainer and teachers trained) _____

Describe when Parent/guardian should be notified: _____

Reviewed by:

Director: _____

_____ **Date**

Health Consultant: _____

_____ **Date**

Teachers: _____

_____ **Date**

Health Care Provider: _____
(If possible)

_____ **Date**

Next Review Date: _____