MEDICAL ACTION CARE PLAN

Child's Name: _____ **Date of Birth** _____/_____/_____

Parent / Guardian Name: _____

Emergency Phone Numbers: Parent/Guardian: _____ If no answer call: _____*See emergency contact information for alternate contacts if parents are unavailable)*

Primary Health Care Provider: _____

Phone #: _____

To be completed by the Healthcare Provider/Physician

DIAGNOSIS: 1. _____ 2. _____

Administer the Emergency Medication listed below when child has the following medical emergency:

_____

_____

Emergency Medication	Schedule (when)	Dose (How much)	Route (How)	Possible Side Effects
	***MUST match prescription label**	***MUST match prescription label**		

CALL PARENT'S FOR:_____

GET MEDICAL ATTENTION FOR:_____

CALL 911 FOR:_____

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state and federal laws and regulations.

Health Care Provider Signature: _____

Date: _____

To be completed by the Parent/Guardian

I have developed this health plan in partnership with my child's healthcare provider and Head Start staff. I will communicate any changes in my child's identified health condition or treatment to Head Start staff as changes occur.
Effective _____Expires _____This plan will be reviewed and updated annually.

As the parent/legal guardian of _____(Child's Name), I _____(Parent/Guardian Name) give my Permission for OVEC Staff to administer the Emergency Action Plan including the administration of Medication as stated in this plan. I further release OVEC and its employees from any claims or liability connected with its reliance on this permission

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date: _____

To be completed by Staff after being trained

By signature, staff acknowledges education by parent or guardian on condition(s) and requirement of emergency care and/or medication if needed.

(All staff in center must be trained):

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____Date: _____