Name of child: _____ St. Paul's Nursery School

Date: _____ Individual Health Care Plan (IHCP)

*PLEASE NOTE – the PARENT/GUARDIAN MUST inform the program IMMEDIATELY if there are ANY changes/adjustments to this plan. The plan is only valid for one year.

- Please ✔ all that apply. This plan is created by: ____Parent ____Doctor or health care practitioner ___Other *please state who:

Name & description of medical condition	Symptoms	Medical treatment necessary while at the program	Potential side effects of treatment	Potential consequences if not treated

Name of Licensed Health Care Practitioner (please print)_____

Licensed Health Care Practitioner signature_____ Date:_____

Parental/Guardian signature _____ Date:_____

----------OFFICE USE ONLY----------

This plan is maintained by:

_____ Director _____ Other – please state who _____

Names of educators who received training addressing this medical condition_____

Person who trained the educators_____ Date_____