

Individual Health Care Plan - Eton School

Child's Name _____
Birth Date _____
Date _____

Parent / Guardian #1

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Alternate Phone _____

Parent / Guardian #2

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Alternate Phone _____

Alternate Emergency Contact #1

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Alternate Phone _____

Alternate Emergency Contact #2

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Alternate Phone _____

Health Care Provider #1

Name _____
Specialty _____
Address _____
Phone _____

Health Care Provider #2

Name _____
Specialty _____
Address _____
Phone _____

Medical Diagnosis

1. _____
2. _____
3. _____

Allergies

Foods _____
Insects _____
Medications _____

Emergency Plan

Please describe any known, possible emergency situation that might happen with your child (i.e. what might the emergency be and what signs will your child show).

Please list in order the steps you would like the staff to take in response to this emergency.

Please identify any ways the staff can help prevent an emergency.

Medications

Medication Name _____

Dosage _____

Schedule (Please include the full day) _____

Possible Side Effects _____

Check if you have given Eton School a three day emergency supply.

Medication Name _____

Dosage _____

Schedule (Please include the full day) _____

Possible Side Effects _____

Check if you have given Eton School a three day emergency supply.

Medication Name _____

Dosage _____

Schedule (Please include the full day) _____

Possible Side Effects _____

Check if you have given Eton School a three day emergency supply.

Care Schedule

Time	Care Needs
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Activities of Daily Living (Use this area to talk about your child's abilities to care for him or herself. Describe what support and/or equipment he/she needs to accomplish these tasks.)

Nutrition (Use this section to talk about your child's nutritional needs. Describe any nutritional formulas, food allergies or restrictions, feeding techniques, precautions or equipment used.)

Respiratory (Use this section to talk about your child's respiratory care needs. Describe the care or treatments your child needs and any special techniques or precautions you use when giving cares.)

Communication (Use this section to talk about your child's ability to communicate and to understand others. Describe how your child communicates. Include sign language words, gestures or any equipment your child uses.)

Mobility (Use this section to talk about your child's ability to get around. Include any equipment your child uses. Describe any activity limits and any special routines your child has for transfers, pressure releases, positioning, etc.)

Rest / Sleep (Use this section to talk about your child's nap and sleep schedule. Describe any routines, security objects that help your child.)

Social / Play (use this section to talk about your child's ability to get along with others. Describe what works best to help your child get along or cooperate with others. Describe your child's favorite things to do.)

Health Care Provider's Signature (Required)

Date

Parent / Guardian's Signature (Required)

Date

À

Signatures of Staff Trained in the Above Plan (and Date):
