Child Health Plan and Provider Orders -
Other Health Conditions

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center:	☐ ECEAP	☐ Head Start	☐ Early Head Start
Child's Name:	**Date of Birth:**		Gender: ☐ M ☐ F
Parent/Guardian:	**Phone:** (Home)		(Cell)
Does this child have any of the following? (check one)	☐ IEP	☐ IFSP	☐ 504 Plan

Health Condition:

Parent/Provider Input:

Child-Specific Emergencies	
If you see this:	**Do this:**

Any program activities where accommodations are needed? (Class, outdoor activities, field trips, nutrition)

Is medication(s) taken at home?	☐ Yes – List:	☐ No
Is medication(s) needed while at school?	☐ Yes – Refer to Provider's Orders	☐ No
Is medication(s) needed during transport to/from school?	☐ Yes	☐ No

This page is to be completed by the Health Care Provider.

Child's Name: **Date of Birth:** **Gender:** ☐ M ☐ F

☐ **No medication is required at school (Skip box and sign below if you agree with this *Child Health Plan*).**

☐ **Medication is required at school (Fill out box and sign below). If medication is taken daily at home, a 3-day supply of medication is needed at school in case of a disaster.**

Health Care Provider Orders for Medication at School

Important notice to Provider:

Please ensure this child has a prescription on file with the pharmacy that matches the orders below.
Our policy requires Health Care Provider Orders and medication labels to match exactly.

1) Medication Name	**2) Symptoms for medication use**	
3) Dose	**4) Frequency & Length of time between doses**	**5) Route**
6) Possible side effects of medication		
7) Special administration and/or storage instructions		
8) If PRN, start date	**and end date**	**required.**

Health Care Provider Signature **Date**

Print Name **Phone #** **Fax #**

Parent/Guardian Signature **Date**

Interpreter Signature **Date**

Nurse Consultant Signature **Date**

ITE/Teacher **Date** **ITP/Assistant** **Date** **FA/FE/FSS/HV** **Date** **Dir/C Coor** **Date**