

**EEC Individual Health Care Plan Form**

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name and Phone Number of Licensed Health Care Practitioner (please print): \_\_\_\_\_

Parental/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_