

After School Club Individual Health Care Plan (IHCP) (rev. 9/21/2010)

This form to be used for all chronic health conditions including
asthma, allergies that require an EpiPen, diabetes, adrenal insufficiency,
seizures, lactose intolerance requiring medication etc.

Child's Name: _____ DOB _____

Check all that apply

Plan is created by:

- Parent/ Guardian
- Doctor or Practitioner
- Program Health Consultant
- Other: _____

Plan is maintained by:

- Co-Directors
- Administrative Assistant
- Education Co-Ordinator
- Other: _____

This health plan is developed to ensure to the best of the ASC's ability that the health care requirements of children are met and inclusive of children with disabilities

Parent _____ cell # _____

Plan includes written parent consent (Medication Consent Form) Yes

Parent _____ cell # _____

Plan includes Doctor or Practioner Authorization on file (Medication Consent Form)

home # _____

Please fill in all of these boxes in detail

Medical Condition	Symptoms	Treatment	Side Effects of Treatment	Consequences if not treated

IHCP includes Additional Information attached: Yes No Staff has been trained by t parent Staff has been trained _____

*(Parent / Guardian must inform the After School Club immediately if there are **ANY** changes or adjustments to this plan. Plan is valid for one year and must be reviewed and validated annually.)*

 Parent / Guardian signature Date ASC Signature

There are NO changes to my child's HC plan

 Parent / Guardian signature Date ASC Signature

There are NO changes to my child's HC plan

 Parent / Guardian signature Date ASC Signature

There are NO changes to my child's HC plan

 Parent / Guardian signature Date ASC Signature