Child Medical Action Plan

10A NCAC 09 .0801(b) [Centers] and .1721(a)(4) [Family Child Care Homes]

If a child has health care needs that require specialized health services**,** the child's parent or a health care professional should complete a medical action plan and attach it to the child's application. The plan must be updated annually and stored in the child's file and facility's Ready to Go File. A copy should be kept in the classroom.

Children with asthma, diabetes, seizures, or allergies should have medical action plans specific to those conditions.

Name of person completing form:		Today's date:
Child's full name:		Date of birth:
Parent/guardian's name:		Phone:
Primary health care professional:		Phone:
Specialist/therapist:	Type:	Phone:
Specialist/therapist:	Type:	Phone:
Diagnosis(es):		
Allergies (food, medication, environmental, insects, or other):		

Medication(s)

Complete a **Medication Administration Permission Form** if medications listed below are to be provided by the child care. Complete page three if child has more than two medications.

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Accommodation(s)

Describe any accommodation(s) the child needs in daily activities and why.

Diet or Feeding:
Classroom Activities:
Naptime/Sleeping:
Toileting:
Outdoors or Field Trips:
Transportation:
Other/Comments:

Child Medical Action Plan

Equipment/Medical Supplies

1.
2.
3.
4.

Emergency Care

Call parents/guardians if the following symptoms are present:
Call 911 (emergency medical services) if the following symptoms are present, and contact the parents/guardians:
Take these measures while waiting for parents or medical help to arrive:

Suggested Special Training for Staff

If completed by a health care professional:

Health Care Professional Signature:	Date:

Parent notes

Parent/Guardian Signature:	Date:

Child Medical Action Plan

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
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CCDC HEALTH SERVICES
A Ministry of Calvary Church

CCDC MEDICATION/CARE AUTHORIZATION AND RELEASE

Child's Name: _____ Age: _____

☐ *For children with Food or Non-Food allergies, please check*. I acknowledge that Calvary Church, including Calvary Child Development Center, not an allergen-free facility that CCDC cannot guarantee my child will not be exposed notwithstanding awareness of his/her allergies, and he/she may be exposed to an allergen while on-site at CCDC.

For All Medical Action Plans (Food Allergy, Non-Food Allergy, Seizure, or Asthma)
I hereby give permission for my child, while present at CCDC, to receive medication inn accordance with the Medical Action Plan for my child or as otherwise indicated below, as prescribed by a licensed physician. I hereby authorize CCDC, including its directors, staff and volunteers, to administer mediation and to provide or arrange for medical care in accordance with the Medical Action Plan or as indicated below.

For myself and for my child, I release and discharge CCDC, Calvary, its officers, elders, employees, volunteers or other agents from all claims and liability for any loss or injury that may occur in the future as a result of exposure to allergens and any medications or care provided under this authorization and release. I further agree to reimburse, indemnify and hold Calvary and CCDC harmless from any and all costs, claims and liabilities associated with providing or arranging medical care for my child.

Parent/Guardian: _____ Signature: _____ Date: _____

Address: _____ Phone: _____

Medical Need	Medication	Method of Application	Dosage	Prescribed By

Signature of Health Care Provider:
(Doctor, Nurse Practitioner, Physician's Assistant)

Address:

Phone: Date:

(Signature Stamp Required)