Medical Care Plan Form

Facility Name: ______________________________

Child's Name: ______________________________ Date of Birth: ______________________
month/day/year

Parents:

Mother______________________________ Phone # ______________________

Father______________________________ Phone # ______________________

Diagnosis:______________________________

Signs and Symptoms:

- ______________________________
- ______________________________
- ______________________________
- ______________________________

Worst Case Scenario: ______________________________
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Medication Name: ______________________________ **Dose:** ______________________

Care Card Number: ______________________________

Contacts:

Name: ______________________________ Phone #: ______________________

Name: ______________________________ Phone #: ______________________

Name: ______________________________ Phone #: ______________________

Name: ______________________________ Phone #: ______________________

Additional Actions: ______________________________
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If at any time I feel unsure I will call 911 and will request an ambulance.

This care plan was created in conjunction with the parent and will be reviewed at least one per year.

______________________________ ______________________________
Parent/Guardian Signature Licensee/Manager Signature

______________________________ ______________________________
Date Next Review Date