Doña Ana County Head Start
Individual Health Care Plan

Name of child/staff: _________________________________  Date: __________

Center: ____________________________________ AM __ PM __ Full Day __

Health Concern/Diagnosis: ______________________________

Warning Signs & Symptoms: _________________________________________
__________________________________________________________________
__________________________________________________________________

Is child/staff taking prescribed medication?  Yes ___  No ___

If yes, name of medication: _________________________________________

What will be the emergency plan of action if needed:
1. ________________________________  5. ________________________________
2. ________________________________  6. ________________________________
3. ________________________________  7. ________________________________
4. ________________________________  8. ________________________________

What are the activities that cannot be done in the classroom/outdoors:
1. ________________________________  4. ________________________________
2. ________________________________  5. ________________________________
3. ________________________________  6. ________________________________

Emergency Contacts:   Name     Phone #
1. ________________________________   ________________________________
2. ________________________________   ________________________________
3. ________________________________   ________________________________

I, __________________ understand the nature of the above IHCP and
(Signature of Guardian/Staff)
agree to the best of my knowledge that this information is accurate.

____________________________
Date of Signature

IHCP/HN/3.05  6.08 5.12

ENTERED INTO CHILDPLUS
BY:____________________
DATE:___________________