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:_____