East Missouri Action Agency, Inc.
Head Start

Special Health Care Plan

Head Start facility_____

Child's name_____ Date of birth _____

Times and days in Head Start center _____

1. Describe the child's special health need or chronic condition _____

_____

2. What emergency or unusual episode might arise while the child is in care? How should the episode be handled?

3. _____

_____

4. Accommodations which the facility needs to provide for the child _____

_____

4. Emergency medications such as rescue inhaler or epipen in staff fanny pack or apron to be readily accessible in case of emergency.

___Designated staff have been trained and are knowledgeable of location of medication at all times.

This location is (circle one) fanny pack/apron of _____.

When this person is absent the following person(s) will give emergency medications:

1) _____ 2) _____
Documentation: Medication Log; Meeting Participation form

5. Doctor's orders or instructions for emergency care _____

_____

6. Special emergency and/or medical procedures required _____

_____

7. Special training required for staff _____

_____

Please attach documentation from doctor, if applicable

Parent signature _____ Date _____

Family advocate signature _____ Date _____

Teacher signature _____ Date _____

Assistant teacher signature _____ Date _____

Other signature _____ Date _____

All Head Start staff involved must sign form.

Revised 8/11