Agawam School Age Childcare Program
ASAC

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Dear Families,

According to a new regulation from the Massachusetts Department of Early Education and Care the Agawam School Age Childcare Program is required to have an Individual Health Care Plan form on file for any child with allergies or chronic health care conditions. Please have this form completed by your child's health care practitioner and return it to ASAC. Please keep a copy for your records as your child will not be permitted to attend the program without it. If your child is in need of medications while in the care of the ASAC Program we will need you to complete a Medication Consent Form . Medications need to be in their original container with a current prescription attached. Inhalers, Epi-Pens or other emergency medications need to be in the possession of ASAC staff at all times. Unfortunately we can not share medications with school nurses because ASAC does not have access to these medications before or after school hours. Medication prescribed by a physician need to be followed exactly as prescribed. For example **if a twin pack of Epi Pens are prescribed we need 2 Epi Pens** unless the prescribing physician notates only one is needed either in the prescription or on the IHCP form. For the safety of your child he or she will NOT be allowed to begin or remain in the ASAC Program if we do not have the necessary forms or medications.

Thank you,

Andrea Cichetti
ASAC Director

Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply....

Plan was created by:
- __ Parent
- __ Doctor or Licensed Practitioner
- __ Program's Health Care Consultant
- __ Older school age child (9+ yrs. of age)
- __ Other: _____

Plan is maintained by:
- __ Director
- __ Assistant Director
- __ Child's Educator
- __ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? YES (indicate changes below) NO (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription **(applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin **(parent signature only)**

The Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION ADMINISTRATION RECORD

(This record must be maintained in the children's file when completed)
606 CMR 7.11 (1-3)

FOR STAFF USE:
Who trained the staff? _____
Has the Medication Consent form been completed? ____
Have the "5 rights" been addressed? ____
Is the medication in a safety cap container? ___
Is the original prescription label on the medication container? ___
Is the name of the child given below on the container? ___
Is the date on the prescription current (within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise? ___
Is the dose, name of drugs, frequency of administration given on the label consistent with parental instructions?___

Medication can be administered only if the answers to all questions above are "Yes"

CHILD'S NAME_____**MEDICATION**_____

DATE	TIME	MEDICATION	DOSE	ROUTE	STAFF SIGNATURE	MISDOSES ERRORS	CHILD REFUSAL ☑

Did you check the label 3 times?_____

If child refused medication explain why?_____