

**Maple Tree Childcare Center
Individualized Care Plan and Medication Form**

*This order can be in effect for 6 months from the issue date.
Separate forms are needed for each type of medicine.*

Child's name:	Date of plan:
Date of birth:	Doctor's name:
Mother's name:	Father's name:
Condition the plan addresses:	Allergies:
Medication:	Dosage amount:
Daily frequency of dosage: (Note times of day and/or intervals.)	Medication start date: Medication end date: (Must not exceed 6 months.)

Steps for addressing the condition:

Give the medicine when these signs are observed:	
Child should be sent home when:	
Call 911 when these signs are observed:	
Child may return to school when:	
Parent's signature approving medication and steps: X _____ Date: _____	Doctor's signature approving medication and steps: X _____ Date: _____

Record of administration for the care plan medicine described on the reverse side of this sheet.

Child's name: _____

Name of medication: _____

Dosage amount: _____

	Dosage amount Time Signature	Dosage amount Time Signature	Dosage amount Time Signature	Dosage amount Time Signature
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				
Date				

Remaining medicine:

- Returned to parent
- Discarded
- Used up

Teacher's signature _____

Initials stand for:

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-
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