Super Stars Learning Center

Individualized Health Care Plan

Child's Name: _____

Child's DOB: _____

Condition: _____

Symptoms: _____
_____
_____

Treatment: _____
_____
_____

Potential Side Effects: _____
_____

Consequences if Treatment is not provided:
_____
_____

"I authorize the child's parents or program's Health Care Consultant to train staff on the child's specific medical needs."

_____ _____

Doctor's Signature **Date**

_____ _____

Parent's Signature **Date**