CHRONIC HEALTH CONDITION INDIVIDUAL TREATMENT PLAN AND EMERGENCY CARE PLAN

Child's Name	Today's Date
Parent's Name	Parent's Emergency Phone Number
Child's Doctor's Name	Child's Doctor's Office Phone Number

THE ABOVE MENTIONED CHILD HAS BEEN DIAGNOSED WITH THE FOLLOWING STABLE, CHRONIC HEALTH CONDITION(S)

☐ BLEEDING OR CLOTTING DISORDER
☐ TYPE I DIABETES
☐ TYPE II DIABETES
☐ A CONDITION THAT LIMITS MULTIPLE ACTIVITIES OF DAILY LIVING_____
☐ A CONDITION THAT REQUIRES REGULAR MEDICAL TREATMENT _____

ROUTINE/MAINTENANCE MEDICATION FOR CONDITION:

NAME OF MEDICATION	HOW MUCH TO GIVE	WHEN TO GIVE	HOW TO GIVE

WHEN TO ADMINISTER ADDITIONAL "AS NEEDED" TREATMENT:

TYPE OF EVENT	DESCRIPTION OF SYMPTOMS	WHAT TO DO

ADDITIONAL "AS NEEDED" TREATMENTS (MAGNETS, MEDICATIONS, DEVICES, ETC.) TO USE IN CASE OF ABOVE LISTED EVENTS:

NAME OF TREATMENT	HOW MUCH TO GIVE	WHEN TO GIVE	HOW TO GIVE

CALL 911 IF CHILD EXHIBITS THE FOLLOWING SIGNS OR SYMPTOMS:

_____

_____

SPECIAL INSTRUCTIONS: _____

_____ _____ _____

Physician's Signature Date Parent/ Guardian's Signature Date Sprouts Staff Signature Date