Community Action Head Start
Child Medication Treatment Plan
(503) 581-1152 fax: (503) 581-3012
This form must be completed by your child's doctor or health care professional

Emergency Medication Treatment Plan			
Child's Name:			**Birthdate:___/___/___**
Name of Medication: **Circle either routine or emergency**	**_____** **Routine Emergency** Required at school? **Yes No**	**_____** **Routine Emergency** Required at school? **Yes No**	**_____** **Routine Emergency** Required at school? **Yes No**
When should it be used (symptoms, time of day, frequency, etc.)?			
Amount (dose) of medication?			
How soon should treatment start to work?			
Expected benefit for child?			
Possible side effects, if any?			
Signature of Child's Doctor	**Doctor's Signature:_____ Date: ___/___/____** **Doctor's Name (print):_____**		
Parent/Guardian's permission to follow medication plan	**Parent/Guardian's Signature:_____** **Date : ____/____/____ Telephone: (____) _____-_____**		

In addition to your doctor completing this form, we will need you to attach the following documents/items:

- **Prescribed medication in original container.**
- **Medication label that includes child's first and last name, medication name, date prescription was filled, expiration date, name of prescribing doctor, and the administration, storage, and disposal instructions.**

Please note: All medications must be brought to the classroom by the parent/guardian with all necessary documentation. Medications cannot be transported on the bus (unless the child's condition necessitates medication to be with them at all times).

Copy to Health Specialist Copy to Child's File **Rev. 4/14**