AREA FIVE AGENCY HEAD START

CHILD HEALTH INDIVIDUAL PLAN (CHIP)

Phone (574)722-4451 Fax (574)722-3447

Child's Name _____ **Birth Date** _____

Parent/Guardian(s) _____ **Phone #** _____

Health Care Provider _____ **Phone #** _____

MEDICAL INFORMATION

Diagnosis/Health Concern: _____

Signs/Symptoms: _____

Medications: _____

Special equipment: _____

Plan of Treatment: _____

_____

_____

_____

Ongoing Care and Follow-up Needs/Referrals: _____

EMERGENCY CARE PLAN

Emergency Action Steps:	Call 911 If:	Call Parent If:	While Waiting for Help:

*I have helped develop this health plan. I will communicate any changes in the child's condition or treatment. I understand that this plan will be shared with the staff that will be working with the child who has a Child Individual Health Plan (CHIP).

_____ _____

(Teacher Signature) **Date** **(Health Manager)** **Date**

_____ _____

(Parent Signature) **Date** **(Physician Signature)** **Date**

*I have reviewed and am knowledgeable of this plan. I know where this plan is located. If I have any questions, I will call the Child Health Manager.

_____ _____

(Bus Driver-as needed) **Date** **(Teaching Assistant)** **Date**