Reach-Up
Head Start
Early Head Start

Head Start
Early Head Start

United Way

Health-Plan of Care

Child: _____ D.O.B.: _____ Program Year: _____

Parent/Guardian(s): _____

The above Early Head Start/Head Start Child has an identified health concern. To provide an optimum experience for this child, additional information and instruction is needed from your Health Care Provider. Parent/Guardian signature is also needed where indicated below. Child cannot attend the program without this form completed. Thank you.

HEALTH CARE PROVIDER, PLEASE COMPLETE THE FOLLOWING:

Identified Health Concern:

ASTHMA: _____ DIABETES: _____ SEIZURE DISORDER: _____

OTHER: _____ please specify: _____

Medication is needed during program hours: Yes:_____ No: _____

*If yes, "Permission to Administer Medication" form MUST be completed by the Health Care Provider before medicine can be given by Reach-Up, Inc. staff.

INSTRUCTION FOR CARE: _____ _____

_____

ACTIVITY LEVEL / RESTRICTIONS: _____

EMERGENCY INSTRUCTIONS: _____

_____

OTHER RECOMMENDATIONS: _____

_____

_____

Health Care Provider: _____ Date: _____

Parent/Guardian: _____ Date: _____

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Reach-Up Head Start and Early Head Start provides comprehensive education and support services that strengthen young children and their families who are experiencing low-income.