Child's Name _____

DOB _____

EdAdvance BASES
860-567-0863 x1167
355 Goshen Road, Litchfield, CT 06790

BASES Student Care Plan

Individualized Plan of Care for a Child with Special Health Care Needs or Disabilities

* Staff must refer to Medication Administration forms or complete dosing and administration instructions*

ASTHMA ☐ Yes ☐ No

Medication Name/Dose/Time _____

☐ Asthma Action Plan is signed and dated by PCP, and is attached

Additional instructions (symptoms, triggers, etc.) **See Attached Asthma Action Plan and Medication Authorization from PCP**

ANAPHYLAXIS ALLERGY ☐ Yes ☐ No

Allergy to: _____ ☐ Ingestion Only ☐ Contact or Ingestion

See Attached Treatment/Emergency Plan and Medication Authorization from PCP

If exposure (see above) or insect sting is witnessed or suspected caregiver should

_____ Administer Adrenalin (injectable medication) BEFORE symptoms occur

_____ Administer Adrenalin (injectable medication) IF symptoms occur

_____ Administer Benadryl dose

_____ Administer Adrenalin (injectable medication) _____ FOR _____

_____ Call 911 Transport to Emergency Room if symptoms occur and/or adrenalin is administered

Relevant side effects to be observe, if any _____

NON ANAPHYLAXIS ALLERGY ☐ Yes ☐ No

Allergy to _____ Symptoms/triggers _____

☐ Will not be accesible/served at program ☐ Will keep away from allergen if exposure is possible

OTHER HEALTH CONCERNS ☐ Yes ☐ No

Diagnosis _____ Current Medications _____

Relevant Information (symptoms, triggers, interventions etc) _____

_____

MEDICATIONS NOT ADMINISTERED AT THE PROGRAM ☐ Yes ☐ No

Medication Name	Medication Dose	Medication Dosage Schedule

Dear Parent/Guardian: Please assure that the steps above have been reviewed with you by EdAdvance BASES staff and that it is consistent with your wishes for care of your child while at he/she is attending the EdAdvance BASES Program and is in agreement with instructions from your child's health care provider. Please note any additional instructions in the section provided.

Parent/Guardian Signature _____ **Date** _____

ATTENTION STAFF: Please be sure that the following items are on file

☐ Completed Health Form
☐ Completed Emergency Card
☐ Medication labeled in individual box/bag
☐ Completed Administration of Prescription Medication Form is with the medication

NOTE: Section 19a-79-5a(a)(2)(E) requires a child's Health Record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or vision impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities, The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Section 19a-79-4a(h)(2)(H)(viii) requires that the health care consultant shall assist in the review of individual care plans as needed.