



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

GENERAL CARE PLAN

YMCA OF GREATER HARTFORD

Child's Name: _____ Date of Birth: _____

Diagnosis/Medical History: (please be specific)

Dietary/Nutritional: _____

Gross Motor: _____

Sleep: _____

Communication: _____

Social-Emotional: _____

Other: _____

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

MINOR SYMPTOM	If you see these symptoms, do this:
MAJOR SYMPTOMS	If you see these symptoms, do this:

MEDICATIONS

	Name of Medication	Amount	When to Use
1.			
2.			
3.			

*Authorization for the Administration of Medication form must be on file for each medication.

MEDICATION REQUIREMENTS: (check one)

_____ No medication required while attending YMCA program. Physician initials required: _____

_____ Medication required at the YMCA program. (Bring original prescription to first day of the program, label clearly showing camper's name, birthday, and expiration date)

Child's Name: _____ Date of Birth: _____

Specialist's name & field: _____ Phone number: (____) _____

Specialist's signature: _____ Date: _____

Physician's name: _____ Phone number: (____) _____

Physician's signature: _____ Date: _____

Parent's name: _____ Parent's signature: _____



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STAFF SIGNATURES

I have read and understand the attached Care Plan for: _____

(Child's Full Name)

Staff Name: _____ Staff Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

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Staff Name: _____ Staff Signature: _____ Date: _____

Child's doctor and YMCA program should keep a current copy of this form in child's record.