



# A Celebration of Children

## Individualized Child Care Plan (ICCP) Allergies

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes No

b. If yes, describe how often it occurs. \_\_\_\_\_

c. What symptoms and behavior does your child experience? (Describe allergic reaction.)

How soon after exposure does the allergic reaction begin?

d. List any restrictions at C.D.L.C.

2. Treatment and Medication:

a. Routine treatment(s) and medication(s):

b. As needed (PRN) treatment(s) and medication(s):

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

4. Child's knowledge:

a. What is your child's understanding of the medical condition?

b. Does your child understand about any restrictions at C.D.L.C.?

c. Can your child tell the teacher when treatment and medication is needed? Yes No

d. Does your child cooperate with treatment and medication? Yes No

5. Additional information and/or Health Care Provider's recommendations:

\_\_\_\_\_  
Parent/Guardian Signature – Date

\_\_\_\_\_  
Health Care Provider Signature - Date