



A Celebration of Children

Individualized Child Care Plan (ICCP) Asthma, RAD

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?

1) Early symptoms:

2) Late symptoms:

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