INDIVIDUALIZED CARE PLAN (ICCP) – ALLERGIES

Child's Name: ____ Birth Date:_________________________________

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 CDLC: ____

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 CDLC? ____

   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

____

Teacher Signature - Date