Community Action Team
CHILD & FAMILY DEVELOPMENT PROGRAMS

Individual Care Plan
(For Asthma, Complete Asthma Plan 3-48)

CHILD INFORMATION

Child's Name: _____ Date: _____

Child's DOB: _____ Center: _____

CONTACT INFORMATION

Parent/Guardian's Name _____ Telephone _____

Parent/Guardian's Name _____ Telephone _____

Primary Health Care Provider _____ Telephone _____

Specialist (if applicable) _____ Telephone _____

Parent/Guardian will be notified immediately of any suspected allergic reactions, or if the child came in contact with the allergen even if a reaction did not occur.

CHILD'S SPECIAL MEDICAL INFORMATION

Diagnosis, Signs, and Symptoms:

_____

_____

Describe any modifications that are needed for the child to attend school:

_____

_____

Allergies:

_____

MEDICATION(S) – Prescribed and Over-the-Counter

List medication(s) to be given during school or for an emergency:

Name of Medication	Dosage	Directions	Expiration Date

EMERGENCY RESPONSE PLAN

1. Describe symptoms that would prompt emergency medication to be given:

2. List steps and procedures to follow during an emergency related to the child's special medical condition:

TRAINING FOR STAFF

List training required for staff prior to child attending:

SIGNATURES		DATE
Parent/Guardian's:		
Head Start Staff:		
Health Care Provider:		