Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

Individualized Child Care Plan (ICCP)

Developmental Disabilities or Other Health/Learning Needs
(Such as ADHD, Autism or Emotional/Behavior Disability)

Child's Name: _____ Birth Date: _____

Health Care Provider: Name: _____ Clinic: _____

Address: _____

Telephone Number(s): (_____)_____ (_____) _____

1. Medical and/or Educational Diagnosis: _____

   a. When was your child first diagnosed? (Date) _____

   b. Does your child have a specialized plan? (This plan may be set up by your local school district) Yes ____ No ___

   ☐ Individual Family Service Plan (IFSP) (usually for children birth to 3 years who have a disability)

   Case Manager: _____ Telephone Number: _____

   ☐ Individual Education Plan (IEP) (usually for children ages 3-5 years who have a disability)

   Case Manager: _____ Telephone Number: _____

   c. If your child has a IFSP or IEP, what services are currently provided?

   ☐ OT ☐ PT ☐ Speech ☐ Special Education Teacher

   ☐Other (specify) _____

   d. Are these services provided at:

   ☐ Your home ☐ Your current child care program

   ☐ A specialized child care program – Name: _____

2. Treatment and Medication related to diagnosis (Complete MEDICATION PERMISSION Form):

   a. Medication(s) given at child care: _____

   b. Special medical treatment(s) at child care: _____

3. Other services or behavior plans needed at child care:

   a. What symptoms or behaviors does your child experience? _____

   _____

   b. What situation could trigger these symptoms or behaviors? _____

   _____

   c. List any restrictions at child care: _____

   _____

   d. List any adaptations or changes needed in the classroom: _____

   _____

   e. Any additional plans needed to meet your child's needs: _____

   _____