

# Individualized Child 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 day care:

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

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 day care?

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 Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date: