



INDIVIDUALIZED CARE PLAN (ICP) - ALLERGIES

Child's Name _____ Birth Date _____

Health Care Provider Name _____ Title _____

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. Are 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 _____