INDIVIDUALIZED CARE PLAN (ICCP) – ASTHMA, RAD

Child's Name: _____ Birth Date: _____

Health Care Provider/ Nurse: _____ 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?

      Early symptoms: _____

      Late symptoms: _____

   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