



## INDIVIDUALIZED CARE PLAN (ICP) – ECZEMA/DERMATITIS

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? \_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_