BOYS & GIRLS CLUBS
OF THE RED RIVER VALLEY

Individual Child Care Plan (ICCP): Allergies and Asthma

Child's Name:_____ **DOB:**_____

Site Location:_____

Diagnosed Medical Condition:_____

Is this a current health issue? YES____ **NO**____

If yes, how often does the condition occur:_____

What symptoms and behaviors does your child experience?

Before the reaction:_____

During the reaction:_____

After the reaction:_____

List any program restrictions we should be aware of:_____

What medication and treatment plan is your child following? (If your child will take medication while in our care, a medication permission form must be completed.)_____

_____

If your child does not respond to medication and treatment what would you like the staff to do?_____

_____

Can your child administer the medication and treatment themselves or does your child need help?_____

If assistance is needed, what does the staff need to do? Please note; if staff need to help your child you will need to train them in specifics._____

_____

Where is the medication stored?_____

Is there any additional information staff must know in order to best serve your child?_____

_____

_____

OFFICE USE ONLY

Received by:_____ Date:_____

Copy to Site:_____ Copy to Director:_____ File:_____