Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

Individualized Child Care Plan (ICCP)

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?

   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:

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Individualized Child Care Plan (ICCP)

Developmental Disabilities or Other Health/Learning Needs
(Such as ADHD, Autism or Emotional/Behavior Disability)

Child's Name: _____ Birth Date: _____

Health Care Provider: Name: _____ Clinic: _____

Address: _____

Telephone Number(s): (_____)_____ (_____) _____

1. Medical and/or Educational Diagnosis: _____
   a. When was your child first diagnosed? (Date) _____
   b. Does your child have a specialized plan? (This plan may be set up by your local school district) Yes ____ No ___
      ☐ Individual Family Service Plan (IFSP) (usually for children birth to 3 years who have a disability)
      Case Manager: _____ Telephone Number: _____
      ☐ Individual Education Plan (IEP) (usually for children ages 3-5 years who have a disability)
      Case Manager: _____ Telephone Number: _____
   c. If your child has a IFSP or IEP, what services are currently provided?
      ☐ OT ☐ PT ☐ Speech ☐ Special Education Teacher
      ☐Other (specify) _____
   d. Are these services provided at:
      ☐ Your home ☐ Your current child care program
      ☐ A specialized child care program – Name: _____

2. Treatment and Medication related to diagnosis (Complete MEDICATION PERMISSION Form):
   a. Medication(s) given at child care: _____
   b. Special medical treatment(s) at child care: _____

3. Other services or behavior plans needed at child care:
   a. What symptoms or behaviors does your child experience? _____
   _____
   b. What situation could trigger these symptoms or behaviors? _____
   _____
   c. List any restrictions at child care: _____
   _____
   d. List any adaptations or changes needed in the classroom: _____
   _____
   e. Any additional plans needed to meet your child's needs: _____
   _____

4. Implementation of ICCP by child care staff:

   a. Meeting with parent(s)/guardian to set up or review plan. Date _____

   b. All staff that interact with your child have reviewed the plan. Yes _____ No _____ Date _____

   c. All staff have completed training specific to your child's medical/educational needs.

      Yes _____ No _____ Date _____

   d. Center had contacted case manager to coordinate child's ICCP with the IFSP or IEP?

      Yes _____ No _____ Date _____

   e. Center has a copy of current IFSP or IEP. Yes _____ No _____

5. Additional information and/or Health Care Provider's recommendations:

_____ _____

Parent Signature/Date: Health Care Provider Signature/Date *(if appropriate)*

_____

Case Manager Signature/Date *(if appropriate)*

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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:

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Individualized Child Care Plan (ICCP)
Asthma, RAD

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/List triggers: _____
   c. What symptoms and behavior does your child experience?
      1) Early symptoms:
      2) Late symptoms:
   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:

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Individualized Child Care Plan (ICCP)
Seizure

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._____

      Are seizures related to a specific condition?
   c. What symptoms and behavior does your child experience?
      1) Before the seizure:
      2) During the seizure:
      3) After the seizure:
   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: _____

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Individualized Child Care Plan (ICCP)
Eczema/Dermatitis

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/Any known cause? _____
   c. What symptoms and behavior does your child experience?

   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: _____