SPECIAL NEEDS CARE PLAN FOR CHILD CARE (ICCP)

(MUST BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER)

Today's Date_____ **Care Plan 1-year Update Due_____**

Child's Full First and Last Name_____Date of Birth: _____

Diagnosis:_____

Allergies:_____

Emergency Medication Required on site (circle) Yes / No

If Yes, which medications will be on site?

Medication	Amount	Frequency	Route	Reason Prescribed	Possible Side Effects	Expiration Date

Triggers for Diagnosis:_____

Avoidance Techniques:_____

Symptoms Associated With Diagnosis_____

Symptoms Requiring Phone Call To Parent/Guardian:_____

Symptoms Requiring 911 And Emergency Services:_____

Care To Be Given While Waiting For 911 and/or Parents:_____

Please Check And Provide Description For Any Of The Following Special Accommodations Your Child Requires:

☐ **Diet/Feeding_____** ☐ **Sleeping/Napping_____**

☐ **Activities_____** ☐ **Outdoors/Field Trips_____**

☐ **Toileting/Diapering_____** ☐ **Transportation_____**

☐ **Other_____**

Medical Provider Name:_____Medical Provider Phone Number_____

Medical Provider Signature_____

Parent Name_____Parent Phone Number_____

Parent Signature_____