



INDIVIDUALIZED PLAN FOR A CHILD WITH MEDICAL NEEDS

This form must be completed for a child who has one or more acute or chronic** medical conditions such that he or she requires additional supports, accommodation or assistance.*

Child's Full Name: _____

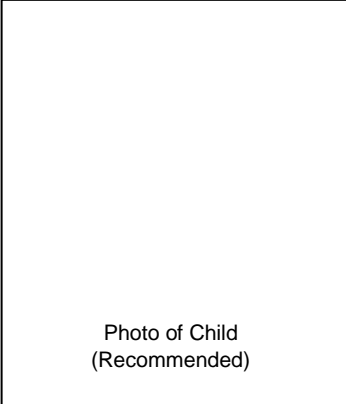
Child's Date of Birth: day _____ month _____ year _____

Date Individualized Plan Completed: day _____ month _____ year _____

Medical Condition(s):

- Diabetes
- Asthma
- Seizure
- Other: _____

Doctor's Name: _____ Phone# _____



Prevention and Supports

STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING THE MEDICAL CONDITION(S):
LIST OF MEDICAL DEVICES AND HOW TO USE THEM (if applicable):
LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S) (if applicable):
SUPPORTS AVAILABLE TO THE CHILD (if applicable):

Symptoms and Emergency Procedures

Attend to the child, call 911, call parents AND follow the procedure outlined below

SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY:
PROCEDURE TO FOLLOW IF CHILD HAS AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY:

PROCEDURES TO FOLLOW DURING FIELD TRIP:

- Ensure this plan is with the child at all times
- Ensure all necessary medication and devices accompany child at all times
- Ensure that all staff on field trip are aware of the child's medical condition and aware of the child's emergency plan

PROCEDURES TO FOLLOW DURING EVACUATION:

- Ensure this plan is with the child at all times
- Ensure all necessary medication and devices accompany child at all times
- Ensure that all staff on field trip are aware of the child's medical condition and aware of the child's emergency plan

Additional Information Related to the Medical Condition (if applicable):

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This plan has been created in consultation with the child's parent / guardian.

Parent/Guardian Signature:

Parent 1 (Print name):	Best phone number to be reached at:	Relationship to child:
Signature:		Date: (day/month/year)
Parent 2 (Print name):	Best phone number to be reached at:	Relationship to child:
Signature:		Date: (day/Month/year)

The following individuals participated in the development of this individual plan (optional):

First and Last Name	Position/Role	Signature

Frequency at which this individualized plan will be reviewed with the child's parent/guardian:

- **As needed**

Date(s) Reviewed: 1st review _____ additional reviews: _____