INDIVIDUALIZED PLAN FOR A CHILD WITH MEDICAL NEEDS

Child's Full Name:

Child's Date of Birth:

Date Individualized Plan Completed:

Medical Condition(s):

☐ Diabetes ☐ Asthma
☐Febrile Seizure ☐ Other : _____

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:
LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S):

Symptoms and Emergency Procedures

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 AN EVACUATION:
PROCEDURES TO FOLLOW DURING FIELD TRIPS:

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

Parent/Guardian Signature:

Print name:	**Relationship to child:**
Signature:	**Date:**

by typing your name above you agree to the above statements