

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:

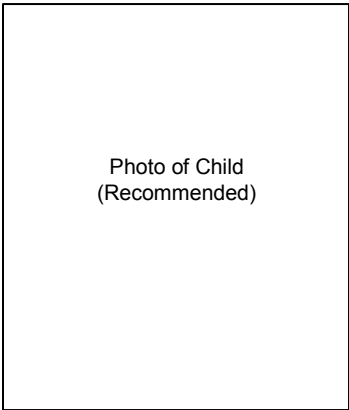
Child's Date of Birth:

(dd/mm/yyyy)

Date Individualized Plan Completed:

Medical Condition(s):

- Diabetes
- Asthma
- 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 (if applicable):
LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S) (if applicable):
SUPPORTS AVAILABLE TO THE CHILD (if applicable):

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 TRIP:

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

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Asthma Only:

Medication:

Use reliever inhaler (name of medication) _____ in the dose of

(# puffs of doses) _____

Chamber provided: Yes _____ No _____

Can the child self-administer? Yes _____ No _____

Contact Information, in case of emergency:

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Managing Asthma Episodes:

Mild Asthma Episodes:

If any of the symptoms occur:

- Continuous coughing
- Difficulty breathing
- Chest tightness
- Wheezing. May also experience restlessness, irritability and/or tiredness

Immediately use the fast acting reliever inhaler (usually blue), have the child rest until all symptoms are gone.

In the event that any of the following occur:

- Breathing is difficult and fast
- Lips or nail beds are blue or grey
- Skin or neck or chest are sucked in with each breath
- Cannot speak more than 5 words between breaths

Call 911 Use reliever inhaler every few minutes until medical help arrives.

While waiting, have child sit up with arms resting on a table (do NOT lie them down) stay calm and reassure them, stay by their side and notify the parent/guardian.

Authorization for administration of medication:

I acknowledge that the staff of Heritage Green Child Care Inc are not trained medical personnel, however, I authorize the administration of medication, as prescribed by the attending physician, in the event my child requires medical intervention. I also understand that my child may need to be held in order to administer medication (inhaler/insulin etc) and consent to the same.

I consent to the posting of photographs of my child and of medical information related to my child (individual Emergency Allergy/Anaphylaxis Action Plan/Asthma Plan/Medical Plan in locations deemed appropriate by HGCC staff.

Self Administration of Medication (if applicable)

I consent to my child carrying an inhaler on his/her person.

Yes: _____

No: _____

I consent to my child self-administrating the prescribed inhaler, if physically capable.

Yes: _____ No: _____

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

Parent/Guardian Signature:

Print name:	Relationship to child:
Signature:	Date: (dd/mm/yyyy)

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

First and Last Name	Position/Role	Signature
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