INDIVIDUALIZED PLAN OF CARE

Child's Name:_____________________________ Teacher(s) Signature:_________________

Date of Birth:____________________________ __________________________________

Allergy/Condition: ____

Reactions: ______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Contact Information:

Parent: _____________________ Home/Work #:____________ Cell#:________________

Parent: _____________________ Home/Work #:____________ Cell#:________________

Dr: _________________________Office:__________________ Phone#_______________

Preferred Hospital:______________________________

Treatment Plan:

1. ____
2. ____
3. ____
4. ____
5. ____

If food allergy/foods child cannot have:

____

____

____

____

Foods Child can have:

____

____

____

____

Picture of Child

Location of child's snack food:

____

____

Parent Review & Signature:_____________________________ Date:________________

Medicine Returned to:________________________________ Date:_________________