**INDIVIDUALIZED PLAN FOR A CHILD WITH A MEDICAL NEED**

Photo of Child (Recommended)

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| Child’s Name: |
| Child's Date of Birth (dd/mm/yyyy): |
| **Date Individualized Plan Completed** (dd/mm/yyyy): |

**Medical Condition(s):**

Diabetes  Other:

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Seizure

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| STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING THE MEDICAL CONDITION:  *(e.g. Pureeing food to minimize choking)* |
| LIST OF MEDICATION/ MEDICAL DEVICES AND HOW TO USE THEM:*(e.g. feeding tube, stoma, glucose monitor, etc.; or not applicable (N/A))* |
| LOCATION OF MEDICAL DEVICES/ MEDICATION:*(e.g. glucose monitor is stored on the second shelf in the program room storage closet; or not applicable (N/A))* |
| SIGNS AND SYMPTOMS OF MEDICAL EMERGENCY: |
| PROCEDURE TO FOLLOW IF MEDICAL EMERGENCY OCCURS: |
| PROCEDURE TO FOLLOW DURING AN EVACUATION or OFF-SITE FIELD TRIP: |
| SUPPORTS AVAILABLE TO THE CHILD: |

**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:**

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| **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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This plan will be reviewed and updated annually or as needed.