

Metropolitan Visiting Nurse Association Individualized Child Care Plan (ICCP)  
Seizure

2021 East Hennepin Avenue, Suite 230  
Minneapolis, MN 55413  
Phone: (612) 378-5800; FAX: (612) 378-5918

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes \_\_\_ No \_\_\_

b. If yes, describe how often it occurs. \_\_\_\_\_

Are seizures related to something special?

c. What symptoms and behavior does your child experience?

1) Before the seizure:

2) During the seizure:

3) After the seizure:

d. List any restrictions at day care:

2. Treatment and Medication (Complete MEDICATION PERMISSION Form):

a. Routine treatment(s) and medication(s):

b. As needed (PRN) treatment(s) and medication(s):

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

4. Child's knowledge:

a. What is your child's understanding of the medical condition?

b. Does your child understand about any restrictions at day care?

c. Can your child tell the teacher when treatment and medication is needed? Yes \_\_\_ No \_\_\_

d. Does your child cooperate with treatment and medication? Yes \_\_\_ No \_\_\_

5. Additional information and/or Health Care Provider's recommendations:

\_\_\_\_\_  
Parent Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date:

2021 East Hennepin Avenue, Suite 230

Eczema/Dermatitis

Minneapolis, MN 55413

Phone: (612) 378-5800; FAX: (612) 378-5918

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes \_\_\_ No \_\_\_

b. If yes, describe how often it occurs/Any known cause? \_\_\_\_\_

c. What symptoms and behavior does your child experience?

d. List any restrictions at day care:

2. Treatment and Medication (Complete MEDICATION PERMISSION Form):

a. Routine treatment(s) and medication(s):

b. As needed (PRN) treatment(s) and medication(s):

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

4. Child's knowledge:

a. What is your child's understanding of the medical condition?

b. Does your child understand about any restrictions at day care?

c. Can your child tell the teacher when treatment and medication is needed? Yes \_\_\_ No \_\_\_

d. Does your child cooperate with treatment and medication? Yes \_\_\_ No \_\_\_

5. Additional information and/or Health Care Provider's recommendations:

\_\_\_\_\_  
Parent Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date:

# Asthma, RAD

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes \_\_\_\_ No \_\_\_\_

b. If yes, describe how often it occurs/List triggers: \_\_\_\_\_

c. What symptoms and behavior does your child experience?

1) Early symptoms:

2) Late symptoms:

d. List any restrictions at day care:

2. Treatment and Medication (Complete MEDICATION PERMISSION Form):

a. Routine treatment(s) and medication(s):

b. As needed (PRN) treatment(s) and medication(s):

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

4. Child's knowledge:

a. What is your child's understanding of the medical condition?

b. Does your child understand about any restrictions at day care?

c. Can your child tell the teacher when treatment and medication is needed? Yes \_\_\_\_ No \_\_\_\_

d. Does your child cooperate with treatment and medication? Yes \_\_\_\_ No \_\_\_\_

5. Additional information and/or Health Care Provider's recommendations:

\_\_\_\_\_  
Parent Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date:

Metropolitan Visiting Nurse Association Individualized Child Care Plan (ICCP)  
Allergies

2021 East Hennepin Avenue, Suite 230  
Minneapolis, MN 55413  
Phone: (612) 378-5800; FAX: (612) 378-5918

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes \_\_\_ No \_\_\_

b. If yes, describe how often it occurs. \_\_\_\_\_

c. What symptoms and behavior does your child experience? (Describe allergic reaction.) \_\_\_\_\_

How soon after exposure does the allergic reaction begin?

d. List any restrictions at day care: \_\_\_\_\_

2. Treatment and Medication (Complete MEDICATION PERMISSION Form):

a. Routine treatment(s) and medication(s): \_\_\_\_\_

b. As needed (PRN) treatment(s) and medication(s): \_\_\_\_\_

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is: \_\_\_\_\_

4. Child's knowledge:

a. What is your child's understanding of the medical condition? \_\_\_\_\_

b. Does your child understand about any restrictions at day care? \_\_\_\_\_

c. Can your child tell the teacher when treatment and medication is needed? Yes \_\_\_ No \_\_\_

d. Does your child cooperate with treatment and medication? Yes \_\_\_ No \_\_\_

5. Additional information and/or Health Care Provider's recommendations: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date:

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Health Care Provider: Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Diagnosed Medical Condition: \_\_\_\_\_

a. When was your child first diagnosed? (Date) \_\_\_\_\_ Is it a current health issue? Yes \_\_\_ No \_\_\_

b. If yes, describe how often it occurs. \_\_\_\_\_

c. What symptoms and behavior does your child experience?

d. List any restrictions at day care:

2. Treatment and Medication (Complete MEDICATION PERMISSION Form):

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4. Child's knowledge:

a. What is your child's understanding of the medical condition?

b. Does your child understand about any restrictions at day care?

c. Can your child tell the teacher when treatment and medication is needed? Yes \_\_\_ No \_\_\_

d. Does your child cooperate with treatment and medication? Yes \_\_\_ No \_\_\_

5. Additional information and/or Health Care Provider's recommendations:

\_\_\_\_\_  
Parent Signature/Date:

\_\_\_\_\_  
Health Care Provider Signature/Date: