300 Madison Ave, Mankato, MN 56001

INDIVIDUALIZED CHILD CARE PLAN (ICCP)

This form allows you to inform Little Stars of specific medical conditions that require special handling at the center. Please fill in this for with the assistance of the child's primary care physician and return it to Little Stars.

Child, Parent, and Health Care Provider Information

Child Last Name:	*Child First Name:*	*Child Date of Birth (mm/dd/yyyy):*	
Parent/Guardian First Name:	*Parent/Guardian Last Name:*	*Phone:*	
Doctor :Last Name:	*Doctor First Name:*	*Doctor Phone:*	
Clinic Name:		*Clinic Phone:*	
Clinic Street Address:	*Clinic City:*	*Clinic State:*	*Clinic ZIP:*

Diagnosed Medical Condition

	Asthma		**Eczema/Dermatitis**		**Seizure**		**Other**
Specific Diagnosis:							
Date First Diagnosed:			Is this a current health issue?:		Yes		No
Frequency of occurrence & known causes/events:							
Symptoms & behaviors experienced by your child							
List any restrictions at day care:							
Routine treatments & medications:							
As needed treatments & medications:							
Note: Medications require a completed Form LS-207 Release to Administer medications.							
What is your child's understanding of the medical condition?							
Does your child understand about any restrictions at day care?					Yes		No
Does your child tell the teacher when treatment or medication is needed?					Yes		No
Does your child cooperate with treatment and medication?					Yes		No
Additional information and / or recommendations:							

Parent/Guardian Signature:	*Date (mm/dd/yyyy)*	*Doctor Signature:*	*Date (mm/dd/yyyy)*