Indelible Impression Learning Center

AUTHORIZED INDIVIDUAL CARE PLAN IN A GROUP CHILD CARE SETTING

SEVERE ALLERGIES

Child's Name: _____Date of Birth_____
Physician's Name: _____ (Typed or Printed)
Physician's Emergency Contact Information: _____

Information to be completed by Child's Primary Care Physician

Allergy to: _____(Use separate form for allergies to more than one item or risk)

Does the allergy or allergic reaction, when active, substantially limits one or more major life activities?
_____yes _____no. If yes, describe the substantial limitation of the life activity (-ies).
_____
_____
__
Signs of allergic reaction specific to this child include:
_____
_____
__
If allergic reaction is suspected child care staff should complete the following emergency steps:

1. _____
2. _____
3. _____
4. _____

Emergency Services should be called if:
_____
_____
__

Physician's
signature:_____Date:_____
*Indelible Impressions Learning Center personnel are no authorized to administer medication by needle injection. Epinephrine or similar project administered by auto-injector may be used if prescribed.

Information to be Completed by the Parent

Parent/Guardian
#1:_____
Name Home# Work# Cell#

Parent/Guardian #2:_____ Name Home# Work# Cell#
INFORMATION RELATED TO THIS MATTER WILL BE MAINTAINED IN STRICT CONFIDENCE, SHARED WITH PERSONNEL OF INDELIBLE IMPRESSIONS LEARNING CENTER ONLY TO ASSURE THE CHILD'S HEALTH CARE NEEDS ARE MET

Physician update required no later than_____. (6 months after date physician signs)

Adopted August 2016

Individual Care Plan-Severe Allergies

Child's Name: _____

Information to be completed by the Parent/Guardian

I give permission for Indelible Impressions Learning Center to follow this plan of care prescribed by the physician. Personnel may not vary from the instructions provided by the physician. I give permission for Indelible Impressions Learning Center to call the health care provider(s) indicated for any additional medical information about my child; during the period my child is enrolled.

_____ _____

Signature of Parent/Guardian Date

I understand that I am responsible for the provision and maintenance of safety equipment or specialty items prescribed by the physician or required by the parent.

I will provide an updated Authorized Individual Care Plan prepared by my child's physician every 6 months hereafter.

_____ _____

Signature of Parent/Guardian Date

RELEASE AND WAIVER OF LIABILITY FOR FIRST AID AND OTHER TREATMENT PRESCRIBED UNDER THE INDIVIDUAL CARE PLAN

I release and forever discharge Indelible Impressions Learning Center, its employees and agents, from any and all liability arising in law or in equity as a result of its employee's performing with reasonable care actions in conformance with the Authorized Individual Care Plan. I hereby release and forever discharge Indelible

Impressions Learning Center related to any damage to equipment or for faulty operation of safety or treatment equipment where it has stored and used these items exercising reasonable care.

_____ _____

Signature of Parent/Guardian Date

Adopted August 2016

Individual Care Plan-Severe Allergies

Child's Name: _____

This Authorized Individual Care Plan has been reviewed by the follow child care providers:

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

The following individuals have received First Aid training related to the administration of epinephrine or other emergency treatment and with regard to this child, any specific training the parent or physician recommends:

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Trainer's Signature: _____Date Trained: _____