AUTHORIZED INDIVIDUAL CARE PLAN IN A GROUP CHILD CARE SETTING

ASTHMA/REACTIVE AIRWAY DISEASE (RAD)

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 or Asthma Specialist

Allergy to:
Does the condition, when active, substantially limit one or more major life activities? _____yes_____no. If yes describe the substantial limitation of the life activity (-ies).

_____
Known triggers for this child's asthma may include:_____
_____
__
Activities restrictions recommended, based on this child's condition (if required, please note the restriction is necessary):

1. _____
2. _____
3. _____

Special considerations for group child care. (Check all that apply and provide a brief explanation.)
__Modified physical activities:_____
__Modified outdoor times or activities_____
__No exposure to animal pets in classroom_____
__Avoid certain foods:_____
__Related emotional or behavior concerns:_____
__Special consideration wile on field trips:_____
__Observation for side effects from medication:_____
__Need to take medication while at the program:_____

__Other:_____
_____
____
Can the child use a flow meter to monitor need for medication in child care? _____Y _____N
If yes, what procedures need to be followed before, during and after the reading?
_____
_____
__
How often has the child needed urgent care from a doctor for an attack of asthma in the last 6 months?
_____
__

Emergency Services should be called
if:_____
_____
__

Physician instruction continued on following page:

Medications for routine and emergency treatment of asthma for :
_____
Child's Name

1. Name of Medication: _____
    * When to use:_____
    * How to use:_____
    * Amount to use:_____
    * How soon should treatment start to work:_____
    * Desired results:_____
    * Possible side effects, if any:_____

2. Name of Medication: _____
    * When to use:_____
    * How to use:_____
    * Amount to use:_____
    * How soon should treatment start to work:_____
    * Desired results:_____

* Possible side effects, if any:_____

3. Name of Medication: _____
   * When to use:_____
   * How to use:_____
   * Amount to use:_____
   * How soon should treatment start to work:_____
   * Desired results:_____
   * Possible side effects, if any:_____

(Note: If more medications are required, please attach additional sheet with physician's signature)

Physician's signature:_____Date:_____

*Indelible Impressions Learning Center personnel are no authorized to administer medication by needle injection nor to perform procedures requiring complex medical training.

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 AS REQUIRED TO ASSURE THE CHILD'S HEALTH CARE NEEDS ARE MET

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

Individual Care Plan-Asthma/Reactive Airway Disease (RAD)

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

Individual Care Plan-Asthma/Reactive Airway Disease (RAD)

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 training related to the administration of asthma medication with regard to this child by the parent or as physician recommends:

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Name: _____Signature: _____ Date: _____

Trainer's Signature: _____Date Trained:_____