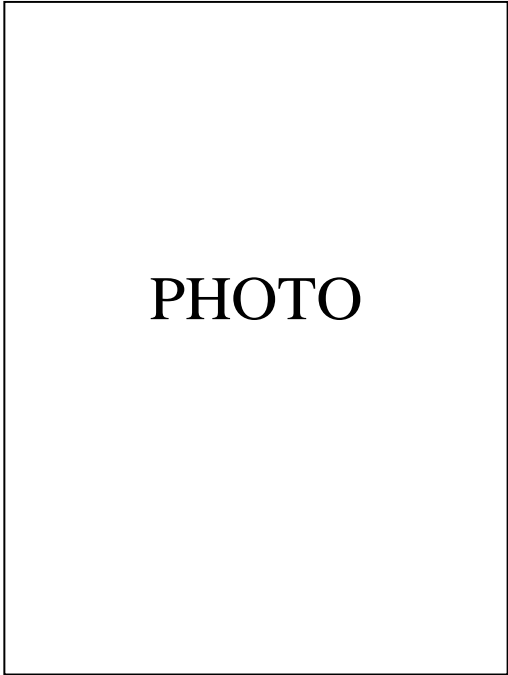




INDIVIDUALIZED PLAN FOR A CHILD WITH MEDICAL NEEDS

CHILD'S NAME: _____ **CHILD'S DATE OF BIRTH:** _____



Date Individualised Plan Completed: _____

Medical Conditions:

- Diabetes Asthma
 Seizure Other: _____

Prevention and Supports

Steps to reduce the risk of causing or worsening medical condition:

List of Medical Devices and how to use them:

Location of Medical Devices: _____

Supports Available to Child:

Symptoms and Emergency Procedures

Signs and Symptoms of an allergic reaction or other medical emergency:

Procedure to follow if child has an allergic reaction or other medical emergency:

Procedure to follow during an evacuation or during field trips:

Additional Information Related to Medical Condition (If applicable)

- This plan has been created in consultation with the child's parent / guardian.

Emergency Contact Information

Name	Relationship	Home Phone	Work Phone	Cell Phone

Parent/Guardian Signature:

Relationship to Child:

Parent/Guardian Name Printed:

Date: