KIDS ZONE
CHILDCARE CENTRE

INDIVIDUAL MEDICAL PLAN (IMP)

Child's Full Name: _____

Child's Date of Birth: _____

Date Individual Plan Completed: _____

Medical Condition(s):

☐ **Diabetes** ☐ **Asthma**

☐ **Seizures** ☐ **Others:**

Prevention and Supports:

Steps to Reduce the Risk of Causing or Worsening The Medical Condition(s):
List Of Medical Devices and How To Use Them:
Location Of Medical and/or Medical Device(s):
Supports Available To The 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:
Procedures to Follow During an Evacuation:
Procedures to Follow During Field Trips:

Additional Information Related to the Medical Condition (if applicable):

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

Parent/Guardian Signature:

Print Name:	**Relationship to the Child:**
Signature:	**Date:** (dd/mm/yyyy)

The following individuals participated in the development of this individual plan (optional):

First and Last name	Position/Role	Signature

Frequency at which this individualized plan will be reviewed with the child's parent/ guardian: