# Appendix C: INDIVIDUALIZED PLAN FOR A CHILD WITH MEDICAL NEEDS

*This form must be completed for a child who has one or more acute\* or chronic\*\* medical conditions such that he or she requires additional supports, accommodation, or assistance.*

**Child’s Full Name:** Click here to enter text.

**Child’s Date of Birth:** Click here to enter text.

**Date Individualized Plan Completed**: Click here to enter text.

**Medical Condition(s):**

Diabetes  Asthma

Seizure  Other:

## Prevention and Support

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| **STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING THE MEDICAL CONDITION(S):** *[Include how to prevent an allergic reaction/other medical emergency; how not to aggravate the medical condition (e.g., Pureeing food to minimize choking)]* |
| **LIST OF MEDICAL DEVICES AND HOW TO USE THEM** (if applicable): *(e.g., feeding tube, stoma, glucose monitor, etc.; or not applicable (N/A))* |
| **LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S)** (if applicable)**:** *(e.g., glucose monitor is stored on the second shelf in the program room storage closet; or not applicable (N/A))* |
| **SUPPORTS AVAILABLE TO THE CHILD** (if applicable)**:** *(e.g., nurse or trained staff to assist with feeding and/or disposing and changing of stoma bag; or not applicable (N/A))*  Click here to enter text. |

## Symptoms and Emergency Procedures

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| **SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY:** *[include observable physical reactions that indicate the child may need support or assistance (e.g., hives, shortness of breath, bleeding, foaming at the mouth)]*  Click here to enter text. |
| **PROCEDURE TO FOLLOW IF CHILD HAS AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY:** *[Include steps (e.g., Administer 2 puffs of corticosteroids; wait and observe the child’s condition; contact emergency services/parent or guardian, parent/guardian/emergency contact information; etc.)]*  Click here to enter text. |
| **PROCEDURES TO FOLLOW DURING AN EVACUATION:** *(e.g., ice packs for medication and items that require refrigeration; how to assist the child to evacuate)*  Click here to enter text. |
| **PROCEDURES TO FOLLOW DURING FIELD TRIPS:** *(e.g., how to plan for off-site excursion; how to assist and care for the child during a field trip)*  Child to have fanny pack on. |

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

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| Click here to enter text. |

**Asthma Only:**

Medication:

**Managing Asthma Episodes:**

**Authorization for administration of medication:**

I acknowledge that the staff of Seaforth Co-operative Children’s Centre Inc. are not trained medical personnel, however, I authorize the administration of medication, as prescribed by the attending physician, in the event my child requires medical intervention. I also understand that my child may need to be held in order to administer medication (inhaler/insulin etc.) and consent to the same.

I consent to the posting of photographs of my child and of medical information related to my child (individual Emergency Allergy/Anaphylaxis Action Plan/Asthma Plan/Medical Plan in locations deemed appropriate by SCCC staff.

**Self-Administration of Medication (if applicable)**

**Yes**  **No**

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

**Parent/Guardian Signature:**

|  |  |
| --- | --- |
| **Print name:** | **Relationship to 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 |
| Click here to enter text. | Click here to enter text. |  |

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