Community **Action** Partnership of Ramsey & Washington Counties

# General Medical Needs: Individualized Child Care Program Plan

| | |
|---|---|
| Date: | |
| Child's Full Name: | Date of Birth: |
| Center: | Center License Number: |

*Child has a special need requiring an ICCPP (See Minnesota Rules, part 9503.0065, subpart 1 A).*

**For Consulting Professional to Fill Out! Please fill out through the signature on Page 2.**

**Describe the medical condition/special need: (Please including when diagnosed, severity, and triggers)**

| | |
|---|---|
| **Date Diagnosed:** | **Severity:** |
| **Triggers:** | |

**Is the child on any daily maintenance medication related to this diagnosis?** ☐ **Yes** ☐ **No**

**If so, what is the medication?**

**Is medication required for the child while in child care, including emergency medication?** ☐ **Yes** ☐ **No**

**Medication Required (name and dosage):**

**Frequency:**

**How to Give:**

**Possible Side Effects:**

**Possible signs/symptoms of a medical emergency related to the condition and the actions to take:**

- **If difficulty breathing/asthma, please include green, yellow, and red zones plan.**
- **If seizures, please include the typical length of seizure and behavior before and after seizure.**

**What modifications, accommodations, or restrictions are needed in the classroom? Outside, on field trips, or on transportation?**

Child's Full Name: Date of Birth:

**ICCPP consultation**

The ICCPP must be coordinated with any ISP, IEP, IFSP, 504 plans, and reports from the licensed physician, licensed psychiatrist, licensed psychologist, or licensed consulting psychologist, per Minnesota Rules, part 9503.0065, subpart 3.

**I attest that the above information is true to my best knowledge and that I am a provider for the child**. By checking "I agree" and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. In addition, I attest and certify that I have verified the above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

**Additional reports/documentation from the consulting professional are attached.**

**Consulting Professional Signature:** **Doctor's Name:** **Phone Number:**

**I agree** ☐ **Signature:** **Date:**

**For Head Start to fill out:**

**What training, staffing, or materials are needed to support the above medications, accommodations, or restrictions?**

**Head Start Nurse Signature:**

**I agree** ☐ **Signature:** **Date:**

**Consents/ Permission for Parents to Fill Out**

- I give my permission for Head Start Staff to administer the prescribed medication, as directed. The parent / guardian will provide the medication for Head Start Staff to administer. Medication must be in original labeled container. (When you get the prescription filled, please ask the pharmacist to put the medication in 2 containers – one for home and one for school.)
- I give my permission for Head Start Staff to follow this plan.
- I give my permission for a copy of this A Plan to be posted in the child's Head Start Center and on the child's Head Start Bus.
- This form must be reviewed and resigned annually. Parents / Guardians may revoke any of the permissions in this form, at any time, in writing to the Head Start Health Services.

**Parent Signature:**

**I agree** ☐ **Signature:** **Date:**

Child's Full Name: Date of Birth:

**Staff Caring for the Child**

| Print Staff Name | Signature | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Complete below for changes and yearly review only**

**Yearly review and changes for ICCPP - Special Need**
Individual Child Care Program Plan - Special Need is to be reviewed at least once each calendar year or when updates are needed per Minnesota Rules, part 9503.0065, subpart 3.

**No changes at yearly review /// Changes at yearly review or as needed**