Individualized Child Care Program Plan (ICCPP)
Asthma

Child's Name: _____Child's DOB: _____

Description of Asthma Concerns: _____

Specific Triggers: _____

Avoidance Techniques: _____

Symptoms of Asthma or Asthma Attack:

Procedures for Responding to an Asthma Attack or Asthma Symptoms at Spartan Kids' Care:
(please only list medication and dosage that you supply Spartan Kids' Care)

Medication: _____

Dosage: _____

If no medication is provided, how would you like Spartan Kids' Care to respond to an asthma attack or asthma symptoms?

IMPORTANT NOTES: If your child requires medication related to asthma, it is required that an **Asthma Control Plan** is submitted to Spartan Kids' Care, along with the medication in its original container with a prescription label. This also applies for over-the-counter medications. **THIS MUST BE COMPLETED BEFORE YOUR CHILD MAY START CARE.**

Doctor Contact Information:

Name_____

Phone Number:_____

Parent Name: _____

Parent Signature:_____Date:_____

- **This form expires one year from the date of signature.**