



Individualized Child Care Program Plan (ICCPP) Other Health Concerns

Child's Name: _____ Child's DOB: _____

Description of Health Concern: _____

Symptoms of Health Concern:

Procedures for Responding to the Health Concern 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 the health concern?

IMPORTANT NOTES: If your child requires medication related to a health concern, it is required that a **Procedures for Dispensing Medication at School** form is submitted to Spartan Kids' Care or **Care Plan** signed by the child's doctor, 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.