St. Paul's Nursery School
Individual Care Plan

My child, _____ has been diagnosed with the following allergy/illness/ chronic condition:

_____

_____

_____

If the student is exhibiting the following signs or symptoms:

_____

_____

Administer the following medications in the following order, as prescribed by the child's physician.

	Medication(s) in order of administration	My child **has** previously received this medication	My child **has not** previously received this medication
1.			
2.			
3			

*__If warranted, St. Paul's Nursery School of Fairfield, Inc. has my permission to administer the initial dose of medication(s) _____(parent initial)_____(Dr. initial)__

Contact the following persons in the following order. (If we administer an Epi-pen, we always call 911 first.):

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____

Prescribing Physician _____ Phone _____

Child's Pediatrician _____ Phone _____

Signature of Parent/Guardian _____ Date _____

Signature of Prescribing Physician_____Date_____

Signature of Staff Member _____Date _____