

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)	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 _____