Adventure Club
Individualized Care Plan

Child's Name____ Date of Birth_______/_______/_______

School_______________________________________

Is your child under care of any specialist? YES NO

Type of care being received:

- O Daily Medication
- O Psychological Counseling
- O Social Worker
- O Physician/Allergist
- O Speech/Physical Therapy
- O Other ____________________

Diagnosis: (Please Print)

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Treatment (Including specific strategies for dealing with special needs): (Please Print)

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Medication (List name, dosage, side effects, etc.): Will this medication be given at Adventure Club? YES NO (Please Print)

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If the child is to receive treatments during their scheduled hours at Adventure Club, how and by whom is this treatment to administered?(Please Print)

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Are there any symptoms, indications or possible problems relating to child's conditions or treatment that we should look for or be aware of? (Please Print)

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Signature of Physician/Specialist: ____ Date: _______________

Parent's acknowledgment: ____ Date: ____________________

Fax to (573) 884-0737

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