YMCA of
Northeastern Ontario
Child, Youth and Family Development

Individual Medical Plan (IMP) (For A Child With Medical Needs) – ***Fillable Electronic Copy***

This form must be completed by the child care supervisor in accordance with instructions by the child's parent and/or medical professional for a child who has one or more acute or chronic** medical conditions such that he or she requires additional supports, accommodation or assistance.*

Child's Full Name: Click here to enter text.

Child's Date of Birth: Click here to enter text.
(dd/mm/yyyy)

Date Individualized Plan Completed: Click here to enter text.

Photo of Child
(Recommended)

Medical Condition(s):

☐ Diabetes ☐ Asthma
☐ Seizure ☐ Other: Click here to enter text.

Prevention and Supports

STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING THE MEDICAL CONDITION(S): *[Include how to prevent an allergic reaction/other medical emergency; how not to aggravate the medical condition (e.g. Pureeing food to minimize choking)]*
Click here to enter text.

LIST OF MEDICAL DEVICES AND HOW TO USE THEM (if applicable): *(e.g. feeding tube, stoma, glucose monitor, etc.; or not applicable (N/A))*
Click here to enter text.

LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S) (if applicable)**:** *(e.g. glucose monitor is stored on the second shelf in the program room storage closet; or not applicable (N/A))*
Click here to enter text.

SUPPORTS AVAILABLE TO THE CHILD (if applicable)**:** *(e.g. nurse or trained staff to assist with feeding and/or disposing and changing of stoma bag; or not applicable (N/A))*
Click here to enter text.

Symptoms and Emergency Procedures

SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY: *[include observable physical reactions that indicate the child may need support or assistance (e.g. hives, shortness of breath, bleeding, foaming at the mouth)]*
Click here to enter text.

PROCEDURE TO FOLLOW IF CHILD HAS AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY: *[Include steps (e.g. Administer 2 puffs of corticosteroids; wait and observe the child's condition; contact emergency services/parent or guardian, parent/guardian/emergency contact information; etc.)]*
Click here to enter text.

PROCEDURES TO FOLLOW DURING AN EVACUATION: *(e.g. ice packs for medication and items that require refrigeration; how to assist the child to evacuate)* Click here to enter text.
PROCEDURES TO FOLLOW DURING FIELD TRIPS: *(e.g. how to plan for off-site excursion; how to assist and care for the child during a field trip)* Click here to enter text.

Additional Information Related to the Medical Condition (if applicable):

Click here to enter text.

☐ This plan has been created by and/or in consultation with the child's parent/guardian.

Parental Consent Statement

I Click here to enter text. (parent/guardian) hereby give consent for my child

Click here to enter text.(child's name) to (check all that apply):

☐carry their emergency medication in the following location (e.g. blue fanny pack around their waist): Click here to enter text.

☐self-administer their own medication in the event of a medical emergency

AND/OR

I Click here to enter text. (parent/guardian) hereby give consent to any person with training on this plan to administer my child's emergency medication and to follow the procedures set out in my child's Individualized Medical Plan and Emergency Procedures.

Parent/Guardian initials: _____

EMERGENCY CONTACT INFORMATION

Contact Name	Relationship to Child	Primary Phone Number	Additional Phone Number
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

HEALTHCARE PROFESSIONAL CONTACT INFORMATION: (optional)

Contact Name	Primary Contact Number
Click here to enter text.	Click here to enter text.

SIGNATURE OF HEALTHCARE PROFESSIONAL (optional)

X	Date:Click here to enter text.

SIGNATURE OF PARENT/GUARDIAN (required)

Print name:	Relationship to Child: Click here to enter text.
X	Date: Click here to enter text.

Frequency at which this individualized plan will be reviewed with the child's parent/guardian:
Click here to enter text.

Important: Staff, Students and Volunteers sign-off and a Dispensing Record is attached to all Individual Medical Plans.

Special Instructions:

- *Acute: a condition that is severe and sudden in onset that, if left untreated, could lead to a chronic syndrome.
- **Chronic: a long-developing syndrome that can develop or worsen over an extended period of time.
- Each child with medical needs requires their own individualized plan. If significant changes and updates are required to this individualized plan, a new individualized plan must be completed.
- An additional individualized plan is not required for a child with an anaphylactic allergy, if the child does not otherwise have a medical need, as these children must already have an individualized plan under the anaphylactic policy (an Individual Anaphylactic Plan should be completed).
- Children's personal health information should be kept confidential.

To be Completed by all YMCA Child Care Staff, Placement Students & Volunteers

Child's Name: _____

The **YMCA Child Care Procedure for Children with Medical Needs** must be reviewed with a signed acknowledgement upon commencement of YMCA employment, student placement or volunteer role and annually thereafter. In addition, after any revision of this form, it will be reviewed by all child care staff, placement students and volunteers.

By signing below, I acknowledge that I have been trained on how to treat the above-named child in the event of a medical emergency and that I fully understand and agree to abide by the **YMCA's Care Procedure for Children with Medical Needs and this Child's Individual Medical Plan**.

Should I have any questions or concerns regarding any YMCA Policy or Procedure, I may contact my YMCA child care supervisor or refer to our Child Care Legislation & Procedures Manual.

Acknowledgement Record of All Child Care Staff, Placement Students or Volunteers

Date	Staff, Placement Student or Volunteer First/Last Name	Signature

**** This original will be kept in the child's file with a copy to be posted in all program areas (anywhere the child may attend) with a cover page for confidentiality and attached to the educators' clipboard.***

Dispensing Record - To be Completed by Child Care Staff

Child's Name: _____

Medication: □ **Puffer** □ **Insulin** **Other**: _____

Date	Time	Dosage Given & Additional Notes	Staff Signature

When the above form is full, please begin a new form and attach the forms together (if the medication is being continued). Please sign and date the below <u>when no longer required</u>.

Parent/Guardian Signature: _____ Date: _____

YMCA Staff Signature: _____ Date: _____