Camp Korp Southington
Individual Care Plan

Child's Name _____ Date of Care Plan ___/___/___ to ___/___/___
Child's Date of Birth ___/___/___

Special Health/Behavioral Concerns
Please check yes to all that apply. If necessary, please specify on the line provided.

Yes

- O Allergies (food, medication, insects, environment, etc)_____
- O Asthma_____
- O Vision, Hearing, Speech_____
- O Diabetes_____
- O Chronic Illness_____
- O Seizures_____
- O Dietary Needs_____
- O Developmental Variations_____
- O Emotional/Behavioral_____
- O Other_____

Symptoms / Medication / Process of Care
For each Yes answer checked above, please provide the following information.

Health Concern #1:_____

Symptoms:_____

On-Site Medication:

- ☐ Yes
- ☐ No

Steps of Care:

1._____

2. _____

3. _____

4. _____

Additional Information: _____

Health Concern #2:_____

Symptoms:_____

On-Site Medication:

☐ Yes

☐ No

Steps of Care:

1._____

2. _____

3. _____

4. _____

Additional Information: _____

Health Concern #3:_____

Symptoms:_____

On-Site Medication:

☐ Yes

☐ No

Steps of Care:

1._____

2. _____

3. _____

4. _____

Additional Information: _____

Name of Health Care Provider: _____ Phone: (_____) _____

Parent/Guardian Signature: _____ Date_____/_____/_____

*****FOR ADMINISTRATIVE USE ONLY*****

Eric Korp, Camp Director:_____ Date:_____

Caroline Natelli, Asst. Director:_____ Date:_____

Jillian Korp, Admin:_____ Date:_____

Counselor:_____ Date:_____

Counselor:_____ Date:_____

Counselor:_____ Date:_____

Nurse:_____ Date:_____