# CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

**-To be completed by a health care provider each year and/or as needed-**

| Center Name | Today's Date |
|---|---|
| Child's Full Name | Date of Birth |
| Parent's/Guardian's Name | Telephone No.<br>(    ) |
| Primary Health Care Provider | Telephone No.<br>(    ) |
| Specialty Provider | Telephone No.<br>(    ) |
| Specialty Provider | Telephone No.<br>(    ) |
| Diagnosis(es) | |
| Allergies | |

**ROUTINE CARE**

*Please ensure that "Dispense of Medication Form" is filled and signed by parents/guardians.*

| Medication To Be Given at Child Care | Schedule/Dose (When and How Much?) | Route (How?) | Reason Prescribed | Possible Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List medications given at home:

**NEEDED ACCOMMODATION(S)**

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: ______________________________

Classroom Activities: ______________________________

Naptime/Sleeping: ______________________________

Toileting/Potty Training: ______________________________

Outdoor or Field Trips: ______________________________

Transportation: ______________________________

Other: ______________________________

Additional Comments: ______________________________

______________________________

**OTHER SERVICES**

| ☐ Physical Therapy | ☐ Occupational Therapy | ☐ Speech & Language Therapy |
|---|---|---|
| ☐ Mental Health Professional Services | ☐ Suspected Disability ________________ | ☐ Suspected Behavior _________________ |

# CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

**Continued**

| **SPECIAL EQUIPMENT / MEDICAL SUPPLIES** | |
|---|---|
| 1. _____<br>2. _____<br>3. _____ | |
| **EMERGENCY CARE** | |
| **CALL PARENTS/GUARDIANS** if the following symptoms are present:<br>_____<br>_____ | |
| **CALL 911 (EMERGENCY MEDICAL SERVICES)** if the following symptoms are present, as well as contacting the parents/guardians:<br>_____<br>_____ | |
| **TAKE THESE MEASURES** while waiting for parents or medical help to arrive:<br>_____<br>_____<br>_____ | |
| **SUGGESTED SPECIAL TRAINING FOR STAFF** | |
| _____<br>_____<br>_____ | |
| Health Care Provider Signature | Date |
| **PARENT NOTES (OPTIONAL)** | |
| _____<br>_____<br>_____ | |
| I hereby give consent for my child's health care provider or specialist to communicate with my child's childcare provider or school nurse to discuss any of the information contained in this care plan. I am also in agreement with the plan developed above for my child, and I will communicate any changes in my child's condition or treatment to center staff. I understand that I have the right to revise or cancel this plan at any time. | |
| Parent/Guardian Signature | Date |
| Center Staff | Date |

**Important:** *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs*


Revised: 2/20/2023

Board Approved:

HSPC Approved: