

## 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. (    )	
Primary Health Care Provider			Telephone No. (    )	
Specialty Provider			Telephone No. (    )	
Specialty Provider			Telephone No. (    )	
Diagnosis(es)				
Allergies				
<b>ROUTINE CARE</b>				
<i>Please ensure that "Dispense of Medication Form" is filled and signed by parents/guardians.</i>				
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:				
<b>NEEDED ACCOMMODATION(S)</b>				
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: _____				
<b>OTHER SERVICES</b>				
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech & Language Therapy		
<input type="checkbox"/> Mental Health Professional Services	<input type="checkbox"/> Suspected Disability _____	<input type="checkbox"/> Suspected Behavior _____		

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Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES	
1. _____ 2. _____ 3. _____	
EMERGENCY CARE	
<b>CALL PARENTS/GUARDIANS</b> if the following symptoms are present: _____ _____	
<b>CALL 911 (EMERGENCY MEDICAL SERVICES)</b> if the following symptoms are present, as well as contacting the parents/guardians: _____ _____	
<b>TAKE THESE MEASURES</b> while waiting for parents or medical help to arrive: _____ _____ _____	
SUGGESTED SPECIAL TRAINING FOR STAFF	
_____ _____ _____	
Health Care Provider Signature	Date
PARENT NOTES (OPTIONAL)	
_____ _____ _____	
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