

# Care Plan for a Child with Special Needs in Child Care

Today's Date \_\_\_\_\_

Full Name of Child	Birth Date	Child's Present Weight
Parent's/Guardian's Name (Please * first person to contact.)	Cell/Home/Work Phone #	Signature for Consent*
Emergency Contact Person (Name/Relationship)	Cell/Home/Work Phone #	* Consent for health care provider to communicate with my child's child care provider to discuss information relating to this care plan.
Primary Health Care Provider	Emergency Phone #	Authorization for Release of Information Form completed? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty Provider	Emergency Phone #	Emergency Information Form for Children With Special Needs completed? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty Provider	Emergency Phone #	Specialty Care Plan(s) completed? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify.		
Medical/Behavioral Conditions		
<p>Needed Accommodations: (Please describe accommodation and why it is necessary.)</p> <p>Diet/Feeding</p> <p>Classroom Activities</p> <p>Nap/Sleep</p> <p>Toileting</p> <p>Outdoor or Field Trips</p> <p>Transportation</p>		
Recommended Treatment		
Medications to be Given at Child Care <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, Medication Administration Forms completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specify medications on Medication Administration Forms.		
Medications Given at Home <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, please list in additional information section or attach info.
Special Equipment/Medical Supplies <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, please list in additional information section or attach info.
Special Staff Training Needs <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, please list in additional information section or attach info.
Special Emergency Procedures <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, please list in additional information section or attach info.
Other specialists working with this child <input type="checkbox"/> No <input type="checkbox"/> Yes		
Parent Signature Acknowledging Review of Above Information		
Additional Information/Comments on Child, Family, or Medical Issues		Additional Information Attached <input type="checkbox"/> No <input type="checkbox"/> Yes
Health Care Provider's Signature		Health Care Provider's Name Printed