

SPECIAL NEEDS HEALTH CARE PLAN

-To be approved by a Health Care Provider-

Today's Date

Child' 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

ROUTINE CARE

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: _____
Outdoor or Field Trips: _____
Transportation: _____
For Behavior Changes: _____
Additional comments: _____

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-continued-

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

TAKE THESE MEASURES 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 child care provider to discuss any of the information contained in this care plan.

Parent/Guardian Signature

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 the 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.*