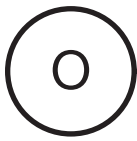


CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

		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				
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: _____				
Other: _____				
Additional comments: _____				



CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
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

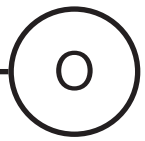
PARENT NOTES (OPTIONAL)

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse 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 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.



Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: _____ Date: _____

Facility Name: _____

.....
Description of condition(s): (include description of difficulties associated with each condition) _____

Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): _____

① If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached Individualized Education Plan (IEP) attached

Outside Professionals Involved

Telephone

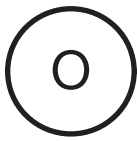
Health Care Provider (MD, NP, etc.): _____	_____
Speech & Language Therapist: _____	_____
Occupational Therapist: _____	_____
Physical Therapist: _____	_____
Psychologist/Mental Health Consultant: _____	_____
Social Worker: _____	_____
Family-Child Advocate: _____	_____
Other: _____	_____

Communication

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

How often will team communication occur: Daily Weekly Monthly Bi-monthly Other _____

Date and time specifics: _____



Specific Medical Information

* Medical documentation provided and attached: Yes No

Information Exchange Form completed by health care provider is in child's file on site.

* Medication to be administered: Yes No

Medication Administration Form completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: _____

Specific health-related needs: _____

Planned strategies to support the child's needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) _____

Plan for absences of personnel trained and responsible for health-related procedure(s): _____

Other (i.e., transportation, field trips, etc.): _____

Special Staff Training Needs

Training monitored by: _____

1) Type (be specific): _____

Training done by: _____ Date of Training: _____

2) Type (be specific): _____

Training done by: _____ Date of Training: _____

3) Type (be specific): _____

Training done by: _____ Date of Training: _____

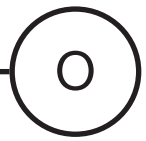
Equipment/Positioning

* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided: Yes No Not Needed

Special equipment needed/to be used: _____

Positioning requirements (attach additional documentation as necessary): _____

Equipment care/maintenance notes: _____



Nutrition and Feeding Needs

Nutrition and Feeding Care Plan Form completed by team is in child's file on-site. (See for detailed requirements/needs.)

Behavior Changes (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

Support Programs the Child Is Involved with Outside of Child Care

1. Name of program: _____ Contact person: _____
Address and telephone: _____
Frequency of attendance: _____

2. Name of program: _____ Contact person: _____
Address and telephone: _____
Frequency of attendance: _____



3. Name of program: _____ Contact person: _____
Address and telephone: _____
Frequency of attendance: _____

Emergency Procedures

Special emergency and/or medical procedure required (additional documentation attached)

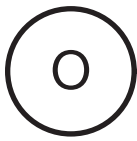
Emergency instructions: _____

Emergency contact: _____ Telephone: _____

Follow-up: Updates/Revisions

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every _____ months as a result of the collective input from team members.

Due date for revision and team meeting: _____



Nutrition and Feeding Care Plan

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child's diet and feeding needs for this child while in child care.

Name of Child: _____ **Date:** _____

Facility Name: _____

.....
Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering *Nutrition and Feeding Care Plan*): _____

① If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached Individualized Education Plan (IEP) attached

Communication

What is the team's communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.):

How often will team communication occur: Daily Weekly Monthly Bi-monthly Other _____

Date and time specifics: _____

Specific Diet Information

* Medical documentation provided and attached: Yes No Not Needed

Specific nutrition/feeding-related needs and any safety issues: _____

* **Foods to avoid (allergies and/or intolerances):** _____

Planned strategies to support the child's needs: _____

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): _____

* Food texture/consistency needs: _____

* Special dietary needs: _____

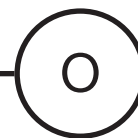
* Other: _____

Eating Equipment/Positioning

* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided Yes No Not Needed

Special equipment needed: _____

Specific body positioning for feeding (attach additional documentation as necessary): _____



Behavior Changes (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

Medical Information

Information Exchange Form completed by Health Care Provider is in child's file onsite.

* Medication to be administered as part of feeding routine: Yes No

Medication Administration Form completed by health care provider and parents is in child's file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

Tube Feeding Information

Primary person responsible for daily feeding: _____

Additional person to support feeding: _____

Breast Milk Formula (list brand information): _____

Time(s) of day: _____

Volume (how much to feed): _____ Rate of flow: _____ Length of feeding: _____

Position of child: _____

Oral feeding and/or stimulation (attach detailed instructions as necessary): _____

Special Training Needed by Staff

Training monitored by: _____

1) Type (be specific): _____

Training done by: _____ Date of Training: _____

2) Type (be specific): _____

Training done by: _____ Date of Training: _____

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

Emergency Procedures

Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: _____

Emergency contact: _____ Telephone: _____

Follow-up: Updates/Revisions

This Nutrition and Feeding Care Plan is to be updated/revised whenever child's health status changes or at least every ___ months as a result of the collective input from team members.

Due date for revision and team meeting: _____