Care Plan: _____

(Child' First and Last Name)

Child's Birth Date		Child's Height		Child's Weight	

Parent's (Guardian) Name		**Cell Phone Number**	
		Work/Home Number	
Emergency Contact Person (Name/Relationship)		**Phone Number**	
Primary Health Care Provider		**Phone Number**	
Specialty Provider		**Phone Number**	

Child Health Information: *(Please attach additional information/documentation as needed)*

My child has a special health care need or diagnosis: □ Yes □ No	If yes, please specify	
Allergies: □ Yes □ No	If yes, please specify	
Medication Needs: □ Yes □ No	If yes, please specify	
Diet/Feeding Needs: □ Yes □ No	If yes, please specify	
Sleeping Needs: □ Yes □ No	If yes, please specify	
Toileting Needs: □ Yes □ No	If yes, please specify	
Equipment/Medical Supply Needs: □ Yes □ No	If yes, please specify	
Other Needs: □ Yes □ No	If yes, please specify	

Child Developmental Information: *(Please attach additional information/documentation as needed)*

My child has special developmental needs: □ Yes □ No	If yes, please specify	
Developmental Accommodations Needed: □ Yes □ No	If yes, please specify	
Additional Developmental Information		

Child Behavioral Information: ***(Please attach additional information/documentation as needed)***

My child has special behavioral needs: ☐ Yes ☐ No	If yes, please specify	
Possible Causes/Purposes for Behavior:	☐ NA ☐ Tension Release ☐ Frustration ☐ Attention Getting ☐ Access to Restricted Items	☐ Escape ☐ Poor Self Regulation Skills ☐ Developmental Disorder ☐ Neurological ☐ Other:_____
Behavioral Accommodations Needed: ☐ Yes ☐ No	If yes, please specify	
Specific Equipment Needs Related to Behavior: ☐ Yes ☐ No	If yes, please specify	
Additional Information regarding behavioral needs:		

Other important Information about child:_____
_____
_____

Child receives additional services related to medical, developmental, or behavioral needs. (Early Intervention, Outpatient Therapy, Psychological Services, Regular Medical Follow up, School Special Education Services, etc). ☐Yes ☐No
If yes, please list: _____
_____

Staff need the following training, related to medical, developmental, or behavioral needs, to care for child: _____
_____
_____

Consent for health care or other provider to communicate with my child's child care provider to discuss information relating child's medical or behavioral needs. ☐Yes ☐No ☐NA

Date Plan Written:_____ Date to Review Plan:_____
Health Care (or other provider) Signature_____ Date:_____
Parent/Guardian Signature_____ Date:_____
Child Care Provider Signature_____ Date:_____

Form provided by Child Care Aware® of North Dakota Health Consultants.
Revised 2/22