

Special Health Care Plan

Full Name of Child	Birth Date	Child 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"/> Yes <input type="checkbox"/> No If Yes, please specify.		
Medical Conditions		
<p>Needed Accommodations: (Please describe accommodation and why it is necessary.)</p> <p>Diet/Feeding:</p> <p>Classroom Activities: Toileting:</p> <p>Nap/Sleep Outdoor or Field Trips:</p> <p>Transportation:</p>		
Recommended Treatment		
Medications to be given at child care? <input type="checkbox"/> Yes <input type="checkbox"/> No 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"/> Yes <input type="checkbox"/> No If yes, please list in additional information section or attach info.		
Special Equipment/Medical Supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list in additional information section or attach info.		
Special Staff Training Needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list in additional information section or attach info.		
Special Emergency Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list in additional information section or attach info.		
Other specialist working with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Parent Signature Acknowledging Review of Above Information		
Additional Information/Comments on Child, Family, or Medical Issues Additional information attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health Care Provider's Signature	Health Care Provider's Name Printed	

Resources : ECELS-Healthy Child Care PA; PA Chapter, American Academy of Pediatrics 9-2010

Form provided by Child Care Aware® of North Dakota Health Consultants.

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