

**PLACE
PICTURE
HERE**

Inclusive Care Plan: _____

(Child's First and Last Name)

Child's Birth Date		Child's Height		Child's Weight	
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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:	Y NA Y Tension Release Y Frustration Y Attention Getting Y Access to Restricted Items	Y Escape Y Poor Self Regulation Skills Y Developmental Disorder Y Neurological Y 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. YYes YNo YNA

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