PLACE PICTURE HERE

Inclusive Care Plan: _____

(Child's 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 CCA of ND Health & Safety Specialists.
Revised Jan2024