****

**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 ordiagnosis: Yes No | If yes, please specify |  |
| Allergies: Yes No | If yes, pleasespecify |  |
| 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 DevelopmentalInformation |  |

Care Plan Page 2

**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 Parent/Guardian Signature Child Care Provider Signature

Date: Date: Date:

*Form provided by CCA of ND Health & Safety Specialists.*

*Revised 6/23*

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