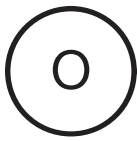


CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

		Today's Date		
Child's Full Name		Date of Birth		
Parent's/Guardian's Name		Telephone No. ()		
Primary Health Care Provider		Telephone No. ()		
Specialty Provider		Telephone No. ()		
Specialty Provider		Telephone No. ()		
Diagnosis(es)				
Allergies				
ROUTINE CARE				
Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects
List medications given at home:				
NEEDED ACCOMMODATION(S)				
Describe any needed accommodation(s) the child needs in daily activities and why:				
Diet or Feeding: _____				
Classroom Activities: _____				
Naptime/Sleeping: _____				
Toileting: _____				
Outdoor or Field Trips: _____				
Transportation: _____				
Other: _____				
Additional comments: _____				



CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

SUGGESTED SPECIAL TRAINING FOR STAFF

Health Care Provider Signature

Date

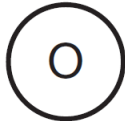
PARENT NOTES (OPTIONAL)

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature

Date

Important: In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.



Special Health Care Plan

To be completed by the Child Care Health Consultant or Health Advocate. The Special Health Care Plan provides information on how to accommodate the special health concerns and needs of this child while attending an early care and education program.

Name of Child: _____ Date: ___/___/___

Name of Child Care Program: _____

Description of Health Condition(s)

List description each health condition:

Team Member Names and Titles (include parents)

Parent/Guardian _____

Health Care Provider (MD, NP) _____

On-site Care Coordinator _____

Team Members; Other Support Programs Outside of Child Care (name, program, contact information, frequency)

Physical Therapist (PT) _____

Occupational Therapist (OT) _____

Speech & Language Therapist: _____

Social Worker: _____

Mental Health Professional/Consultant: _____

Family-Child Advocate: _____

Other: _____

Communication

The team will communicate: Daily Weekly Monthly Other _____

The team will communicate by: Notes, Communication log, Phone, E mail, In Person Meetings,

Other _____ Dates and times _____

Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) is attached. Yes No

Staff Training Needs

Type of training: _____

Training will be provided by: _____

Training will be monitored by: _____

Staff who will receive training: _____

Dates for training: _____

Plan for absences of trained personnel responsible for health-related procedure(s):



Special Health Care Plan

Medical Information

Medical information from the Health Care Provider is attached: Yes No

Information Exchange Form cchp.ucsf.edu/InfoExchangeForm has been completed

by Health Care Provider: Yes No

Medication to be given: Yes No

Medication Administration Form has been completed by health care provider and parents: Yes No

Allergies: Yes No if yes, list: _____

Safety

Strategies to support the child's needs and safety issues while in child care: (e.g., diapering/toileting, outdoor play, circle time, field trips, transportation, nap/sleeping) _____

Special equipment: _____

Positioning requirements: _____

Equipment care/maintenance: _____

Nutrition and Feeding Needs

A Nutrition and Feeding Care Plan has been completed Yes No

Allergies to food: Yes No if yes, list: _____

Other feeding concerns: _____

Behavior Concerns

List specific changes in behavior that arise as a result of the health-related condition/concerns _____

Emergencies

Emergency contact: _____ Telephone: _____

Health Care Provider: _____ Telephone: _____

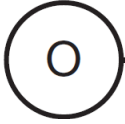
Emergency Information Form Completed Yes No

Follow-up, Updates, and Revisions

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every _____ months as a result of the collective input from team members.

Due date for revision and team meeting: ____/____/____.

Attach additional information if needed. Include unusual episodes that might arise while the child is in care, how the situation should be handled, and special emergency or medical procedures that may be required.



Nutrition and Feeding Care Plan

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child's diet and feeding needs for this child while in child care.

Name of Child: _____ Date: _____

Facility Name: _____

.....
Team Member Names and Titles (parents of the child are to be included)

Care Coordinator (responsible for developing and administering *Nutrition and Feeding Care Plan*): _____

① If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached Individualized Education Plan (IEP) attached

Communication

What is the team's communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.):

How often will team communication occur: Daily Weekly Monthly Bi-monthly Other _____

Date and time specifics: _____

Specific Diet Information

❖ Medical documentation provided and attached: Yes No Not Needed

Specific nutrition/feeding-related needs and any safety issues: _____

❖ **Foods to avoid (allergies and/or intolerances):** _____

Planned strategies to support the child's needs: _____

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): _____

❖ Food texture/consistency needs: _____

❖ Special dietary needs: _____

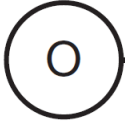
❖ Other: _____

Eating Equipment/Positioning

❖ Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided Yes No Not Needed

Special equipment needed: _____

Specific body positioning for feeding (attach additional documentation as necessary): _____



Behavior Changes (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

Medical Information

Information Exchange Form completed by Health Care Provider is in child's file onsite.

❖ Medication to be administered as part of feeding routine: Yes No

Medication Administration Form completed by health care provider and parents is in child's file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

Tube Feeding Information

Primary person responsible for daily feeding: _____

Additional person to support feeding: _____

Breast Milk Formula (list brand information): _____

Time(s) of day: _____

Volume (how much to feed): _____ Rate of flow: _____ Length of feeding: _____

Position of child: _____

Oral feeding and/or stimulation (attach detailed instructions as necessary): _____

Special Training Needed by Staff

Training monitored by: _____

1) Type (be specific): _____

Training done by: _____ Date of Training: _____

2) Type (be specific): _____

Training done by: _____ Date of Training: _____

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

Emergency Procedures

Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: _____

Emergency contact: _____ Telephone: _____

Follow-up: Updates/Revisions

This Nutrition and Feeding Care Plan is to be updated/revised whenever child's health status changes or at least every ___ months as a result of the collective input from team members.

Due date for revision and team meeting: _____