CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
-To be completed by a Health Care Provider-

<table>
<thead>
<tr>
<th>Child’s Full Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent’s/Guardian’s Name</td>
<td>Telephone No.</td>
</tr>
<tr>
<td>Primary Health Care Provider</td>
<td>Telephone No.</td>
</tr>
<tr>
<td>Specialty Provider</td>
<td>Telephone No.</td>
</tr>
<tr>
<td>Specialty Provider</td>
<td>Telephone No.</td>
</tr>
<tr>
<td>Diagnosis(es)</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
</tbody>
</table>

### ROUTINE CARE

<table>
<thead>
<tr>
<th>Medication To Be Given at Child Care</th>
<th>Schedule/Dose (When and How Much?)</th>
<th>Route (How?)</th>
<th>Reason Prescribed</th>
<th>Possible Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: 

Source: New Jersey Department of Health and Senior Services, 2005.
## CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

### Continued

<table>
<thead>
<tr>
<th>SPECIAL EQUIPMENT / MEDICAL SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

### 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

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: _______________________________________________  Date: __________________________

Facility Name: _______________________________________________

Description of condition(s): (include description of difficulties associated with each condition) ______________________________________

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

Care Coordinator (responsible for developing and administering the Special Health Care Plan): ________________________________

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

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

Outside Professionals Involved

Health Care Provider (MD, NP, etc.): _____________________________

Speech & Language Therapist: _________________________________

Occupational Therapist: ______________________________________

Physical Therapist: __________________________________________

Psychologist/Mental Health Consultant: _________________________

Social Worker: ______________________________________________

Family-Child Advocate: _______________________________________

Other: ______________________________________________________

Communication

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

________________________________________________________________________

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

Date and time specifics: _____________________________________________

Reprinted with permission from California Childcare Health Program (CCHP). Copyright © 2004. Copying any portion of this material is not permitted without written permission of CCHP.
Specific Medical Information

* Medical documentation provided and attached: □ Yes □ No

□ Information Exchange Form completed by health care provider is in child’s file on site.

* Medication to be administered: □ Yes □ No

□ Medication Administration Form completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: ________________________________

Specific health-related needs: ______________________________________________________

__________________________________________________________

Planned strategies to support the child’s needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.)

__________________________________________________________

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

__________________________________________________________

Other (i.e., transportation, field trips, etc.): ________________________________

__________________________________________________________

Special Staff Training Needs

Training monitored by: ________________________________

1) Type (be specific): ________________________________ Date of Training: ________________________________

Training done by: ________________________________ Date of Training: ________________________________

2) Type (be specific): ________________________________ Date of Training: ________________________________

Training done by: ________________________________ Date of Training: ________________________________

3) Type (be specific): ________________________________ Date of Training: ________________________________

Training done by: ________________________________ Date of Training: ________________________________

Equipment/Positioning

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

Special equipment needed/to be used: ________________________________

Positioning requirements (attach additional documentation as necessary): ________________________________

Equipment care/maintenance notes: ________________________________
Nutrition and Feeding Needs

☐ Nutrition and Feeding Care Plan Form completed by team is in child’s file on-site. (See for detailed requirements/needs.)

Behavior Changes (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

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

Support Programs the Child Is Involved with Outside of Child Care

1. Name of program: ____________________________  Contact person: ____________________________
   Address and telephone: ____________________________
   Frequency of attendance: ____________________________

2. Name of program: ____________________________  Contact person: ____________________________
   Address and telephone: ____________________________
   Frequency of attendance: ____________________________

3. Name of program: ____________________________  Contact person: ____________________________
   Address and telephone: ____________________________
   Frequency of attendance: ____________________________

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

Emergency Procedures

Emergency instructions: ____________________________
________________________________________________________
________________________________________________________

Emergency contact: ____________________________  Telephone: ____________________________

Follow-up: Updates/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: ____________________________
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):

☐ 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: ________________