# 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>
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<tbody>
<tr>
<td>Parent’s/Guardian’s Name</td>
<td>Telephone No. ( )</td>
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<tr>
<td>Primary Health Care Provider</td>
<td>Telephone No. ( )</td>
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<tr>
<td>Specialty Provider</td>
<td>Telephone No. ( )</td>
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## Diagnosis(es)

### Allergies

### ROUTINE CARE

<table>
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<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>
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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

### SPECIAL EQUIPMENT / MEDICAL SUPPLIES

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### EMERGENCY CARE

**CALL PARENTS/GUARDIANS** if the following symptoms are present:

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

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

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### SUGGESTED SPECIAL TRAINING FOR STAFF

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**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

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**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.): __________________________ Telephone __________________________

Speech & Language Therapist: __________________________ Telephone __________________________

Occupational Therapist: __________________________ Telephone __________________________

Physical Therapist: __________________________ Telephone __________________________

Psychologist/Mental Health Consultant: __________________________ Telephone __________________________

Social Worker: __________________________ Telephone __________________________

Family-Child Advocate: __________________________ Telephone __________________________

Other: __________________________ Telephone __________________________

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: __________________________
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: __________

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: ____________________________

☐

Emergency Procedures

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

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: ____________________________

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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: ______________