### 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>
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<tr>
<td>Primary Health Care Provider</td>
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<td>Specialty Provider</td>
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<td>Specialty Provider</td>
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<td>Diagnosis(es)</td>
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<td>Allergies</td>
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#### 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

**Continued**

#### SPECIAL EQUIPMENT / MEDICAL SUPPLIES

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#### EMERGENCY CARE

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

- [Blank line]
- [Blank line]
- [Blank line]

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

- [Blank line]
- [Blank line]
- [Blank line]

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

- [Blank line]
- [Blank line]
- [Blank line]

#### SUGGESTED SPECIAL TRAINING FOR STAFF

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Health Care Provider Signature  

Date

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#### PARENT NOTES (OPTIONAL)

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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): _________________________________________________________

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: ________________________________
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: ________________________________

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

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

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: ________________________________
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): ____________________________ Date of Training: ____________________________

Training done by: ____________________________ Date of Training: ____________________________

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

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: ____________________________