

# Care Plan for Children with Special Health Care Needs

Today's Date: \_\_\_\_\_

Child: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Parent(s) or Guardian(s): \_\_\_\_\_

Phone # : \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

Phone # : \_\_\_\_\_

Specialty Provider: \_\_\_\_\_

Phone # : \_\_\_\_\_

Specialty Provider: \_\_\_\_\_

Phone # : \_\_\_\_\_

DIAGNOSIS: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

## Routine Care

Medication	Schedule / Dose (When & How Much)	Route (How)	Reason Prescribed	Possible Side Effects

## Describe any needed accommodations the child's needs in daily activities and why

• Diet or Feeding: \_\_\_\_\_

• Classroom Activities: \_\_\_\_\_

• Naptime/Sleeping: \_\_\_\_\_

• Toileting: \_\_\_\_\_

• Outdoor Activities/Field Trips: \_\_\_\_\_

• Transportation: \_\_\_\_\_

• Other: \_\_\_\_\_

## Special Equipment/Medical Supplies

1

2

3

## EMERGENCY CARE

CALL PARENTS FOR:

While waiting for parent(s) or medical help to arrive

GIVE AS NEEDED OR EMERGENCY MEDICATION FOR:

Medication	Schedule / Dose (When & How Much)	Route (How)	Possible Side Effects

GET MEDICAL ATTENTION FOR:

CALL 911 (Emergency Medical Services) FOR:

## Suggested Special Training for Staff

Signature:

Date: