Written Care Plan

Certified Centers 414-300-0040(3)(b); Certified School-age Centers: 414-310-0580; and Certified Family 414-350-0060(2)(b)

When caring for a child who has, or is at, increased risk for a chronic physical, developmental, behavioral, or emotional condition and who requires services beyond that required by children generally, a child care program must have a written care plan.

ABOUT ME

Child's First Name:	**Last Name:**	**Middle:**	**Sex:**	**Birthdate:**	**Age:**

My family wants you to know:

My preferences include:

Diagnosis/diagnoses or description of health condition(s):

Allergies:

❑ Allergy care plan attached (if needed)

Areas of Challenge or Difficulty (check all that apply)

☐	Mobility	☐	Orthopedic	☐	Stamina/Fatigue	☐	Maintaining Safety
☐	Vision	☐	Sensory Processing	☐	Sleep	☐	Behavioral
☐	Learning	☐	Communication	☐	Feeding/Swallowing	☐	Other:
☐	Hearing	☐	Respiratory	☐	Diet		

Stimulus that may cause a reaction or series of reactions

Triggers to avoid:

Signs and symptoms to watch for:

Helpful strategies used at home:

EMERGENCY RESPONSE PLANS

CALL PARENTS /GUARDIANS if the following:

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following:

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

Special factors to consider in a facility emergency, like a fire:

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

MEDICATIONS (*Complete a medication authorization form)

Medication to be given at child care	**When / Symptoms**	**Dose (How Much)**	**Reason Prescribed**	**Possible side effects**

Medication given at home:

PRIMARY TEAM MEMBERS name and contact information	
Parent/Guardian	Contact information
Parent/Guardian	Contact information
Primary Child Care Caregiver	Contact information
Health Care Provider (MD, NP)	Contact information
Other Team Members / Support Programs (name, program, & contact information, if applicable)	
Public/private School Teacher	
Occupational therapist (OT)	
Physical Therapist (PT)	
Speech/Language Therapist	
Transportation	
Social Worker	
Specialist	
Other	

SERVICES AND PROGRAMS			
Public/Private School name: Phone number:			
Services:	☐ Speech/Language therapy ☐ Physical therapy (PT) ☐ Special Transportation ☐ Occupational therapy (OT) ☐ Augmentative Communication	☐ Behavioral Intervention Plan (BIP) ☐ Individual Education Plan (IEP) ☐ Individual Family Support Plan (IFSP) ☐ Gifted services ☐ 504 Plan	☐ Vision Services ☐ Assistive Technology ☐ Other:

NEEDED MODIFICATIONS or ACCOMMODATION(S)	
Diet or Feeding:	
Activity:	
Napping/Sleeping:	
Toileting:	
Outdoor Play:	
Field Trips:	
Transportation:	
Other:	

SPECIAL EQUIPMENT	
1.	
2.	
3.	

RECOMMENDED SPECIAL SKILLS TRAINING and EDUCATION FOR STAFF		
TRAINING (be specific)	Training to be Completed by	Date

PARENT NOTES	
I hereby give consent for my child's health care provider, and the other team members in this document, to communicate with my child's childcare provider to discuss any of the information contained in this plan and to exchange information necessary to meet the needs of my child.	
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 needs, medications, or emergency care and specific actions. This plan is to be reviewed with you (parent or guardian) and the childcare program every _____ months to ensure that we are both in agreement as to providing the most appropriate care for your child. If your child's needs change before it is time to review the plan, please notify the program immediately so we can update this plan with you as needed.

Completed by: _____ Date _____