Shippensburg Head Start Program
Special Care Plan

Child's Name: _____ **Date of Birth:** ____ ____ ____

Parent's Names: _____

Emergency Phone Numbers: **Mother** _____ **Father** _____

Primary Health Provider's Name: _____ **Emergency Phone** _____

1. Describe the child's special need during group care: _____

2. Child's present functional level and skills: _____

3. What emergency or unusual episode might arise while the child is in care? How should the situation be handled? _____

4. Accommodation which the facility must provide for this child: _____

a) Are there any particular instructions for sleeping, toileting, diapering, or feeding?: _____

b) Will the child require medication while in care? If so, attach the physicians instructions for use of the child's medication.: _____

c) Are special emergency and/or medical procedures required? If so, what procedures are required? _____

d) What special training, if any, must staff have to provide that care?: _____

e) Are special materials/equipment needed?: _____

5. Other specialists working with the child (e.g., occupational theraptist, physical therapist): _____

Medications (routine and emergency): see the chart on page two of this form

_____ ____ ____
Signature of child's parent Date Signed

_____ ____ ____
Signature of child's health provider Date Signed

_____ _____ ____ ____ ____
Name of health professional to call for questions or staff training Phone Number Date to review/update this plan

Medications for routine and emergency treatment of _____ for _____ _____/_____/_____
Child's Name Date of Birth

Name of Medication				
When to use (e.g., symptoms)	Routine or Emergency	Routine or Emergency	Routine or Emergency	Routine or Emergency
How to use				
Amount (dose) of medication				
How soon treatment should start to work				
Expected benefit for the child				
Possible side effects, if any				
Date instructions were last updated by child's doctor	date: ____/____/____ name of doctor: (print) _____ doctor's signature: _____			
Parent's permission to follow this medication plan	date: _____/_____/_____ parent's signature _____			

If more columns are needed for medication or equipment instructions, copy this page