



Care Plan (Special Health Care Needs)

CHILD'S NAME: _____ BIRTH DATE: _____

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

Call Parents/Guardians if the following symptoms are present: _____

Call 911 (Emergency Medical Services) if the following symptoms are present as well as contacting parents/guardians: _____

Take these measures while waiting for parents or medical help to arrive: _____

SUGGESTED SPECIAL TRAINING FOR STAFF

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