JACK & JILL
EARLY CHILDHOOD LEARNING

CHILD SPECIAL NEEDS INDIVIDUAL CARE PLAN

Child's Name _____ **Date of Birth** (mm/dd/yyyy) _____

1 PARENT/GUARDIAN

Name _____
Cell Phone _____
Work Phone _____
Other (home) _____

2 PARENT/GUARDIAN

Name _____
Cell Phone _____
Work Phone _____
Other (home) _____

Primary health care provider's name: _____ emergency phone: _____

Specialist's Name (if any): _____ emergency phone: _____

SPECIAL NEEDS INFORMATION

Diagnosis: _____ **Date of Onset:** _____

Describe the child's special needs during group care: _____

Describe the child's present functional level and skills: _____

Are there any restrictions? _____

Are there any other health (medical, psychological, social) concerns that would help us coordinate the child's care?

Does the child require any specific accommodations in group care?

- Sleeping: _____
- Toileting: _____
- Feeding: _____
- Diapering: _____
- Medications: ☐ Yes (Fill out medication permission form) ☐ No
- Emergency procedures: _____
- Special equipment: _____
- On the playground: _____

Will the staff need special training to provide for this child? ☐ Yes ☐ No

Who will provide the training? _____

X

_____ _____
Physician's Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

TRAINED CHILD CARE PROVIDERS

1. _____ **Room:** _____ **2.** _____ **Room:** _____

PLAN OF CARE REVIEWED BY

Director: _____ **Date:** _____
Teacher: _____ **Date:** _____
Child Care Health Consultant: _____ **Date:** _____
Projected date of plan re-evaluation: _____

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