FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Individual Plan of Care

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

Program Name: _____

Medical Diagnoses (if known)

1.
2.
3.

Health Care Provider Contact Information

Health Care Provider #1	Phone:
Name: _____ Specialty: _____ Address: _____ _____	(____) _____
Health Care Provider #2	**Phone:**
Name: _____ Specialty: _____ Address: _____ _____	(____) _____

Medications

Medication	Dosage	Route	Time/Frequency	Possible Side Effects

1. Child needs to take medication when at center/school:
   ☐ **Yes** (complete attached Medication Authorization Form(s)) ☐ **No**

2. Child has a 3-day emergency supply of medication at center/school:
   ☐ **Yes** (complete attached 3-Day Critical Medication Form) ☐ **N/A**

Allergies

Food	Symptoms of Reaction	Insect/Medication	Symptoms of Reaction
1. 2. 3.		1. 2. 3.	

☐ The Allergy Care Plan has been completed

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Parent/Guardian Contact Information

Parent/Guardian	Phone:
Name: _____ Relation: _____	(____) _____
Parent/Guardian	**Phone:**
Name: _____ Relation: _____	(____) _____

Emergency Contact Information

Emergency Contact #1	Phone:
Name: _____ Relation: _____	(____) _____
Emergency Contact # 2	**Phone:**
Name: _____ Relation: _____	(____) _____

Care in an Emergency

☐ Parent Consent to Emergency Treatment is attached
☐ Exchange of Information forms for community providers (i.e. physicians, OT/PT, Speech Therapists, Mental Health Counselor) is attached

Please describe any known, possible emergency situation that might happen with your child (i.e. what might the emergency be, and what signs will your child show?):
Please list, in order, the steps you'd like the staff to take in response to this emergency:
Please identify any ways staff can help prevent an emergency:

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ACTIVITIES OF DAILY LIVING: Use this area to talk about your child's abilities to care for him or herself, such as toileting, tooth brushing, hand washing. Describe what support and/or equipment s/he needs to accomplish these tasks.
NUTRITION: Use this section to talk about your child's nutritional needs. Describe any nutritional formulas, food allergies or restrictions, feeding techniques, precautions, or equipment used.
RESPIRATORY: Use this section to talk about your child's respiratory care needs. Describe the care or treatments your child needs and any special techniques or precautions you use when giving care.
COMMUNICATION: Use this section to talk about your child's ability to communicate and to understand others. Describe how your child communicates. Include sign language words, gestures, or any equipment your child uses.
MOBILITY: Use this section to talk about your child's ability to get around. Include any equipment your child uses and/or positioning for play. Describe any activity limits and special routines your child has for transfers, pressure releases, positioning, etc.
REST/SLEEP: Use this section to talk about your child's nap and sleep schedule. Describe any routines security objects that help your child.
SOCIAL/PLAY: Use this page to talk about your child's ability to get along with others. Describe what works best to help your child get along or cooperate with others. Describe your child's favorite things to do.

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Care Schedule

TIME	CARE NEEDS	TIME	CARE NEEDS
Morning		**Afternoon**	
Evening		**Night**	

Parent/Guardian: I agree with the above plan of care. I will inform the child care program if child's health status/medication changes.

_____ _(____)_____
Parent/Guardian Name (printed) **Phone Number**

_____ _____
Parent/Guardian Signature **Date**

*** Best practice is to have your child's health care provider review and sign this plan.**
Health Care Provider: I have reviewed and agree with the above care plan. (This authorization is for a maximum of one year from signature date.)

_____ _(____)_____
Health Care Provider Name (printed) **Phone Number**

_____ _____
Health Care Provider Signature (required) **Date**

Child Care Program Staff: This form is active for a maximum of one year from parent's signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition.

This plan is active from: ____/____/____ to ____/____/____.

Staff Trained in the above Plan

Staff Name	Trainer (parent or guardian)	Date