

THE INDIVIDUAL PLAN OF CARE



Child's Name			Date of birth	
DAYS AND TIME IN CHILD CARE				
<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday
EMERGENCY CONTACTS				
Name		Home phone	Work phone	Cell phone
Name		Home phone	Work phone	Cell phone
Name		Home phone	Work phone	Cell phone
CHILD'S HEALTH CARE INFORMATION				
Health care provider		Address		Phone number
Dentist		Address		Phone number

What are the health problems or concerns about your child? _____

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

Is your child taking any medications regularly? Yes No
 If yes, please list medications and schedules, and any important directions. _____

Are special emergency and/or medical procedures required? Yes No
 If so, what procedures are required? _____

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

Are special materials/equipment needed? _____

Other specialists working with the child (e.g., registered dietician, physical therapist):

Does your child require any accommodations in the following areas (diet, toileting, special equipment, change in activity, and other help)? Yes No If yes, please explain

What other information can you share about the strength, assets and interests of your child? _____

Do you have any special hints about techniques you know work well with your child?

Director's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Health Care Provider's Signature _____ Date _____

Dentist's Signature _____ Date _____