Individualized Care Plan for Child with Special Healthcare Needs

The following information is requested for students known to have **special healthcare needs** in order for Wilson Child Care and Early Learning Programs staff to provide your child with the necessary modifications and or adjustments. Please have your child's **physician** complete, sign, and date this form, have a parent/guardian sign and date this form, and return it to the school nurse ***as soon as possible.***

La siguiente información es requerida para estudiantes que tienen **necesidades de salud especiales** para que el personal de Wilson Child Care and Early Learning Programs staff pueda hacer las modificaciones o ajustes específicos. Por favor haga que el **doctor** de su niño complete, firme y ponga la fecha en esta forma. El padre o encargado también debe firmar y poner la fecha en la forma. Por favor devuélvame a la enfermera ***lo más pronto posible.***

Child's Name:	Date of Birth:	Effective Date:
Does the child have a disability that requires modifications to activity? ❒ Yes ❒ No:	If yes, please describe below	
Describe the disability/diagnosis:		
Describe the modifications:		

Medication Orders: (including daily and emergency medications)

Name of Medication:	Dose and Time of Administration (note if needed during school hours)	Side Effects/Special Instructions
Additional Comments:		

Physician Name:	Physician Signature:	Date:
Parent/Guardian Name:	Parent/Guardian Signature:	Date:
Nombre del padre/encargado:	Firma del padre/encargado:	Fecha:

Teachers:
I hereby acknowledge that I have reviewed the above Individualized Care Plan, have received applicable training, have been provided the opportunity to ask questions, and fully understand the above Individualized Care Plan.

Teacher Name:	Teacher Signature:	Date:
Health Specialist Name:	Health Specialist Signature:	Date: