Public Health
Seattle & King County

Individual Care Plan Request Form

Child's name: _____

Child's date of birth: _____

The child listed above attends our child care or early learning program. We have been informed that they have been diagnosed with a medical or behavioral condition that requires specific care or treatment instructions.

Child Care Program Director: _____

Child Care Program: _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

Healthcare Provider: As a licensed child care program, we are required to meet state licensing standards (WAC 110-300-0250 and 110-300-0300). Please complete the following Individual Care Plan and, if necessary, a Medication Authorization Form. We need to know what the child's medical or behavioral condition is, potential triggers, specific treatment instructions while they are at our program and, if necessary, the steps to take during an emergency.

By signing below, I give permission to my child's healthcare provider to release the information requested above to my child care program.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

Individual Care Plan

Child Care Providers: Many health care plans do not meet WAC requirements for child care and early learning programs. The purpose of this checklist is to ensure that the care plan you have on file for a child meets WAC 110-300-0250 and 110-300-0300 requirements for child care and early learning programs. **If the child has been diagnosed with seizures or diabetes, please use the specific checklists for those health conditions.**

This individual care plan is valid until: _____

(Unless otherwise indicated, care plans are valid for 1 year from the date of the healthcare provider's signature on the care plan).

Child's name: _____

Child's date of birth: _____

Medical or behavioral condition(s) (if known)**:** _____

_____

Medications are required for this child's medical conditions: ☐Yes ☐No

- ☐ **A Medication Authorization Form** is required if the child will be given medication by child care staff.
- ☐ **A 3-Day Critical Medication Authorization Form** is required if the child takes life-sustaining medication at home that would need to be given at the child care program if there is an emergency that requires the child to remain in care past usual hours.

Emergency Response Plan

Call parent or guardian if the following medical or behavioral symptoms are present:
Call 911 if the following symptoms are present, as well as emergency contacts:
Steps to take while waiting for the 911 responders to arrive:
Additional healthcare provider notes:

Specific Care and Treatment Instructions

Dietary or Feeding Modifications (not related to food allergy or food intolerance)**:**
Environmental and Activity Modifications (for example: classroom layout, diapering, toileting, naptime or sleeping, outdoor play)**:**
Behavioral Modifications (for example: redirection techniques, activity transition needs)**:**
Special Equipment and Medical Supplies (communication equipment, chairs, sensory toys, durable medical equipment [DME])**:**
Triggers or Stimuli to Avoid:
Suggested Skills or Training for Teachers (for example: pediatric first aid, CPR for special health care needs)**:**

Care Schedule

Time	Care Needs

Healthcare Provider and Parent or Guardian Authorization

Healthcare Provider Name (Printed)**:** _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

Additional Parent or Guardian Notes:

By signing below, I give permission to the child care program listed above to follow the Individual Care Plan as completed and signed by my child's healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Employee Training Record

The parent or guardian has provided training to the employees listed below on the specialized care and treatments listed in this care plan, as ordered by their licensed healthcare provider.

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Additional Care Team Members

Additional care team members for this child are listed below with contact information. This is a “best practice” not a WAC requirement. This may include the physical therapist, speech therapist, occupational therapist, or social worker.

Care Team Member #1

Name: _____

Professional Role: _____

Phone Number: _____

Care Team Member #2

Name: _____

Professional Role: _____

Phone Number: _____

Care Team Member #3

Name: _____

Professional Role: _____

Phone Number: _____

Care Team Member #4

Name: _____

Professional Role: _____

Phone Number: _____

Emergency Contact Information

The emergency contacts for this child are listed below and will be contacted immediately if an emergency occurs. This is a “best practice” for emergency procedures, not a WAC requirement.

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____