

Special Care Plan¹

Full Name of Child	Birth Date	Child's Present Weight
Parent's/Guardian's Name (Please * first person to contact)	Cell/Home/Work Phone #	Signature for consent
Emergency Contact Person (name/relationship)	Cell/Home/Work Phone #	* Consent for health care provider to communicate with shelter provider to discuss information relating to this care plan
Primary Health Care Provider	Emergency Phone #	Notes
Specialty Provider	Emergency Phone #	Notes on Special Care Plan
Allergies (please specify)		
Medical/Behavioral Conditions		
Needed Accommodations: (Please describe accommodation and why it's necessary)		
Diet/Feeding	Toileting	
Activities	Outdoor	
Nap/Sleep	Transportation	
Other:		
Medications & Administration Procedure:		
Special Equipment/Medical Supplies:		
Special Staff Training Needs:		
Special Emergency Procedures:		
Additional Information/Comments:		
Signature of Parent/Legal Guardian:		

¹ Adapted from the State of New Jersey. Please see <http://www.state.nj.us/health/forms/ch-15.pdf> for more information.