

Special Care Plan

This form, completed by a **physician or health care practitioner**, must be provided as part of the complete registration packet.

No substitute form can be provided for pages one and two of this form.

Children who were participating in the Columbia Association School Age Services programs no later than May 1, 2010 have this form on file.

Instructions

Please complete every line of this form. If your child has no special conditions please indicate so by writing "none" in the appropriate spaces.

The Columbia Association School Age Services (SAS) programs operate group care programs and our ratios are 1:15, as required by DHR.

While we will strive to provide as much specialized attention for the children as possible, we are unable to provide 1:1 care or individual companions.

Our programs include group and individual activities, snack and outdoor play.

Child's Name _____ Date of Birth _____

Child's School _____

Medical Condition(s) _____

Please list any medication (including medication that will not be administered during our program) the child is currently receiving: _____

When administered: _____ By whom: _____

Possible side effects of medication: _____

If medication is to be administered at our program a completed medication order form must be submitted to the program director.

Date of child's last tetanus shot: _____



Allergies: _____

Signs and symptoms to look for: _____

If signs appear do this: _____

Please indicate any special accommodations or assistance the child may require. While we will try to meet all reasonable requests through the information provided, all special accommodations may not be possible. _____

Based on the information above, is this child able to function in a group care environment with a 1:15 staff to child ratio? _____



If form is intact (all four pages), the Health Care Practitioner need only sign on page 4.

Parent's Signature _____ Date _____

Signature of Health Practitioner _____ Date _____

Address _____

_____ Phone _____

Health Inventory

Part 2. To be completed by health practitioner.

A similar health inventory that is dated no earlier than one year prior to enrollment date may be provided in lieu of pages three and four of this form provided all of the information requested on this form is provided on the substitute form.

Child's Name _____ Birth Date _____

Child's School _____

Record of Immunization	Dose #	DTP-DT-TD Mo/Da/Yr	Polio Mo/Da/Yr	Hib Mo/Da/Yr	Hep B Mo/Da/Yr	Dose #	M-M-R Mo/Da/Yr	Measles Mo/Da/Yr	Rubella Mo/Da/Yr	Mumps Mo/Da/Yr
	1					1				
	2					2				
	3					Dose	Varicella	Other	Other	Other
	4					1				
5					2					

_____ has had a complete history and physical examination
Child's Name

at my office ____/____/____.

Findings for this child are indicated as follows:

- Date of most recent tuberculin test ____/____/____. Results: _____ Positive _____ Negative
 - Has received appropriate screening and/or testing for lead poisoning on ____/____/____.

2. The child has the following which may significantly affect his education/care experience.

	Yes	No	Comments
a. Visual problems	_____	_____	_____
b. Hearing problems	_____	_____	_____
c. Speech or language problems	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional or behavior problems	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments and recommendations: _____

3. The child has a health condition, which may require care or emergency action while he is at childcare. (Specify, e.g., seizures, bee sting allergy, diabetic, etc.) _____

4. The child has or is a known carrier of a communicable disease. Explain. _____

5. The child is on long-term medication. Specify. _____

6. The child requires a modified diet and /or special feeding procedures. Specify _____

7. Except as noted above, the child is otherwise in good physical and mental health, is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

Answer the following questions only if relevant.

8. If child cannot fully participate in all areas of childcare program, what areas should be limited or altered to suit this child's needs? _____

9. Does child's physical activity need to be restricted? Yes _____ No _____ If yes, explain: _____

10. What specialized treatments, if any, will this child require? _____

Instructions for care: _____

11. Does this child require any supportive equipment (Braces, crutches, etc.)? Yes _____ No _____ If yes, please specify type: _____

Special instructions for use: _____

12. Additional comments: _____

Signature Required

Signature of Health Practitioner Date

Health Practitioner (please print) Phone

Address of Health Practitioner