Inclusive Care Plan

Child's Name		**Child DOB**	
Parent's (Guardian) Name		**Phone Number**	
Emergency Contact Person (Name/Relationship)		**Phone Number**	

Child Health Information: ***(Please attach additional information/documentation as needed)***

My child has a diagnosis: □ Yes □ No	If yes, please specify	
Allergies: □ Yes □ No	If yes, please specify	
Medication Needs: □ Yes □ No	If yes, please specify	
Diet/Feeding Needs: □ Yes □ No	If yes, please specify	
Sleeping Needs: □ Yes □ No	If yes, please specify	
Toileting Needs: □ Yes □ No	If yes, please specify	
Equipment/Medical Supply Needs: □ Yes □ No	If yes, please specify	
Other Needs: □ Yes □ No	If yes, please specify	

Child Developmental Information: ***(Please attach additional information/documentation as needed)***

Developmental Accommodations Needed: □ Yes □ No	If yes, please specify	

Child Behavioral Information: ***(Please attach additional information/documentation as needed)***

My child has special behavioral needs: □ Yes □ No	If yes, please specify		
Possible Causes/Purposes for Behavior:	□ NA □ Tension Release □ Frustration □ Attention Getting □ Access to Restricted Items	□ Escape □ Poor Self Regulation Skills □ Developmental Disorder □ Neurological □ Other:_____	
Behavioral Accommodations Needed: □ Yes □ No	If yes, please specify		
Specific Items Needed Related to Behavior: □ Yes □ No	If yes, please specify		

Please list any additional services related to medical, developmental, or behavioral needs. (Early Intervention, Outpatient Therapy, Psychological Services, Regular Medical Follow up, School Special Education Services, etc.)	

Date Plan Written: _____ **Date to Review Plan:**_____

Plan Written by: _____ _____ _____