**Inclusive Care Plan**

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| **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)***

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| --- | --- | --- |
| 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 |  |

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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**