REQUIRED IF APPLICABLE

Written Care Plan

Oregon DELC PR-0491 · OAR 414-350-0060(2)(b) for certified family child care

When we care for a child who has — or is at increased risk for — a chronic physical, developmental, behavioral or emotional condition, and who needs services beyond what children generally need, we keep a written care plan. We build it **with you**, and we revisit it together.

✦ABOUT ME

FIRST NAME

LAST NAME

MIDDLE

SEX

BIRTHDATE

AGE

MY FAMILY WANTS YOU TO KNOW

MY PREFERENCES INCLUDE

DIAGNOSIS / DIAGNOSES, OR DESCRIPTION OF HEALTH CONDITION(S)

ALLERGIES

☐ Allergy Care Plan attached (if needed)

✦AREAS OF CHALLENGE OR DIFFICULTY

Check all that apply.

☐ Mobility ☐ Orthopedic ☐ Stamina / fatigue ☐ Maintaining safety ☐ Vision ☐ Sensory processing ☐ Sleep ☐ Behavioral ☐ Learning
☐ Communication ☐ Feeding / swallowing ☐ Diet ☐ Hearing ☐ Respiratory ☐ Other

OTHER — PLEASE DESCRIBE

✦WHAT MAY CAUSE A REACTION

TRIGGERS TO AVOID

SIGNS AND SYMPTOMS TO WATCH FOR

HELPFUL STRATEGIES USED AT HOME

✦EMERGENCY RESPONSE PLANS

Call parents / guardians if the following happens

Call 911 (emergency medical services) if the following happens

Take these measures while waiting for parents or medical help to arrive

SPECIAL FACTORS TO CONSIDER IN A FACILITY EMERGENCY, LIKE A FIRE

ADDITIONAL INFORMATION — UNUSUAL EPISODES THAT MIGHT ARISE IN CARE, AND HOW TO HANDLE THEM

✦MEDICATIONS

A medication authorization form must be completed for each medication.

MEDICATION GIVEN AT CHILD CARE	WHEN / SYMPTOMS	DOSE	REASON PRESCRIBED	POSSIBLE SIDE EFFECTS

MEDICATION GIVEN AT HOME

PRIMARY TEAM MEMBERS

ROLE	NAME AND CONTACT INFORMATION
Parent / guardian	
Parent / guardian	
Primary child care caregiver	
Health care provider (MD, NP)	

OTHER TEAM MEMBERS & SUPPORT PROGRAMS

ROLE	NAME, PROGRAM AND CONTACT INFORMATION (IF APPLICABLE)
Public / private school teacher	
Occupational therapist (OT)	
Physical therapist (PT)	
Speech / language therapist	
Transportation	
Social worker	
Specialist	
Other	

SERVICES AND PROGRAMS

PUBLIC / PRIVATE SCHOOL NAME

PHONE NUMBER

SERVICES

- ☐ Speech / language therapy
- ☐ Physical therapy (PT)
- ☐ Special transportation
- ☐ Occupational therapy (OT)
- ☐ Augmentative communication
- ☐ Behavioral Intervention Plan (BIP)
- ☐ Individual Education Plan (IEP)
- ☐ Individual Family Support Plan (IFSP)
- ☐ Gifted services
- ☐ 504 Plan
- ☐ Vision services
- ☐ Assistive technology
- ☐ Other

✦NEEDED MODIFICATIONS OR ACCOMMODATIONS

AREA	WHAT WE'LL DO
Diet or feeding	
Activity	
Napping / sleeping	
Toileting	
Outdoor play	
Field trips	
Transportation	
Other	

✦SPECIAL EQUIPMENT

1

2

3

✦RECOMMENDED TRAINING FOR STAFF

TRAINING (BE SPECIFIC)	TO BE COMPLETED BY	DATE

✦PARENT NOTES

Consent

I give consent for my child's health care provider, and the other team members named in this document, to communicate with my child's care provider to discuss any of the information contained in this plan, and to exchange information necessary to meet the needs of my child.

PARENT OR GUARDIAN SIGNATURE

DATE

COMPLETED BY

DATE

Important. To keep your child healthy and safe, everyone involved in their care needs to know their needs, medications and emergency steps. We'll review this plan with you every _____ months. If your child's needs change before then, tell us right away and we'll update it together.