Valley Shore YMCA Child Care Individual Care Plan

Child's Name_____Date of Care Plan____/___/___ to ___/____/____

Child's Date of Birth____/___/_____Program Site (AM)_____Program Site(PM)_____

Special Health/ Behavioral Concerns

If necessary, please specify on the line provided.

Allergies (food, medication, insects, environmental, etc.)_____

Asthma_____

Vision/Hearing/Speech (glasses, ear tubes, etc)_____ Yes□ No□
Diabetes_____ Yes□ No□
Seizures_____Yes□ No□
Dietary Needs_____ Yes□ No□
Developmental Variations_____Yes□ No□
Emotional / Behavioral _____Yes□ No□
History of Contagious_____Yes □ No□
Other_____Yes□ No□

Symptoms / Medication / Process of Care

For each "yes" answer listed above, please provide the following information.

#1 HealthConcern:_____
Symptoms:_____
On-Site Medication: ☐Yes □ No_____
Steps of Care:_____
_____
_____
_____
_____
_____

Additional Information:_____
#2 HealthConcern:_____

Symptoms:_____

On-Site Medication: ☐YES ☐ No_____

Steps of Care:_____

_____

_____

_____

_____

_____

Additional Information:_____

#3 HealthConcern:_____

Symptoms:_____

On-Site Medication: ☐YES ☐ No_____

Steps of Care:_____

_____

_____

_____

_____

_____

Additional Information:_____

Name of Health Care Provider:_____ Phone: (_____)_____

Parent / Guardian Signature:_____Date:_____

****For Administrative Use Only****

Child Care Staff Signature :_____Date:_____

Child Care Staff Signature :_____Date:_____

Child Care Staff Signature :_____Date:_____

Child Care Staff Signature :_____Date:_____

Child Care Staff Signature :_____Date:_____

Nurse Consultant Review:_____Date:_____