ORFALEA FAMILY CHILDREN'S CENTER
UNIVERSITY OF CALIFORNIA
SANTA BARBARA, CALIFORNIA 93106

SPECIAL HEALTH CARE NEEDS PLAN

Child's Name___________________________________
Parent Names___________________________________
____

Emergency contact ______________________________ Telephone number_____________
Relationship to child ___________________________
Physician's name ______________________________ Telephone number_____________

How do you describe your child's condition/special need to relatives and friends?
____
____
____

When talking with your child about his/her condition, what words do you use?
____
____
____

What words do you want the Center staff to use?
____
____

Child's current diagnosis____
____

How and when was this diagnosis made? (physican, therapist)
____

Is your child currently receiving services from any professionals? If Yes, please list the names, the type of service and how often?

NAME	SERVICE	HOW OFTEN

In order to support our teachers in caring for your child, may the Center contact these professionals? Yes______ No_________

Does your child's condition limit his/her ability to participate in a group setting:
YES___ NO____ If Yes, explain ____
____
____

What special treatments, procedures or care would need to be incorporated to best serve your child in the course of a typical day at the Center ____________________________
____
____

What comforts your child in a non emergency situation?
____
____
____

EMERGENCY PROCEDURES

Describe what a **Medical Emergency** looks like for your child (include symptoms, specific behaviors, change in skin color)
____
____

What comforts your child in an emergency situation?
____
____

In an emergency situation who should be called:

Name	Telephone Number
1.___________________________	______________________
2.___________________________	______________________
3.___________________________	______________________

When Should 911 be called ____

Physician Called____

How much time do we have to respond?____

_________________________________	______________________
Parent's Signature	Date
_________________________________	______________________
Family Coordinator/Program Coordinator	Date

PLEASE COMPLETE THE FOLLOWING INFORMATION WITH YOUR PHYSICAN

Is your child currently taking any medication? YES_____ NO______

If YES, please list below:

1. _______________ Dosage____________ Prescribed for____________ Storage__________
2. _______________ Dosage____________ Prescribed for____________ Storage__________
3. _______________ Dosage____________ Prescribed for____________ Storage__________

Behaviors/symptoms to watch for ____

____

____

If the behaviors/symptoms above are observed, the following action should be taken:

1.____
2.____
3.____
4.____

Procedures

Specific Equipment Medication Dosage

1.____

____

2.____

____

3.____

____

Staff trained to administer procedures

___________________________________ ___________________________________

___________________________________ ___________________________________

List any potential side effects or complications which could happen as a result of the treatment:

1. ____
2. ____

I,____, give my consent for _______________________ who work(s) at_____________________________ to administer medication to my child_________________________________, and to contact my child's health care provider. In addition, I certify that I have personally instructed the above named licensee or staff person on how to administer medication to my child.

Physican's Signature______________________________ Date____________

Parent's Signature________________________________ Date____________

Lead Teacher_____________________________________ Date____________

Program Coordinator______________________________ Date____________