

Proper Care Plan Information

Child's Name: _____

Medical History

1. Special medical conditions _____
2. Chronic illnesses _____
3. History of serious injuries or hospitalizations of which we should be aware _____
4. Diabetes _____ Yes _____ No
- a. If your child has Diabetes, please notify the Director. A Special Care Plan for Children with Diabetes must be completed prior to enrollment.
5. Medication that will be administered regularly at SPCLC _____
6. Special dietary needs _____
7. Physical restrictions _____
8. Is your child able to fully participate in all of the activities offered by SPCLC? ___ Yes ___ No
Explain _____
9. Does your child function at the level of other children in his or her age group? ___ Yes ___ No,
Explain _____
10. Is your child's speech easily understood by most adults? ___ Yes ___ No,
explain _____
11. Can your child effectively communicate his or her needs? ___ Yes ___ No,
Explain _____
12. Does your child require any assistance at mealtime? ___ Yes, explain _____
13. Does your child rest in the middle of the day? ___ Yes ___ No,
Explain _____
14. Does your child use any special equipment, such as a breathing machine, hearing aid, etc.? _____ Yes _____ No
Explain: _____
15. Does your child require one-to-one supervision on a regular basis for a significant period of time?
Yes ___ No ___ Explain _____
16. Does your child require and/or desire any accommodations or modifications to fully and equally enjoy and participate in the SPCLC setting? ___ Yes ___ No
Explain _____

Non-Prescription Medication Products Authorization Form:

All over-the-counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time they are administered.

The following external products may be applied to my child in accordance with the manufacturer's instructions on the original container:

_____ Diaper Wipes	_____ Lip Balm	_____ Sunscreen
_____ Skin lotions/creams	_____ Baby Oil	_____ Soap
_____ Chemical hand sanitizer	_____ Toothpaste	_____ Other: _____

Parent/Guardian's signature _____ Date: ____/____/____

Special Care Plan and Health Needs:

Please provide instructions about any special health needs (allergies, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary or other ongoing health problems): _____

My child requires a care plan (call the St. Pascal School office to request this form. Please advise SPCLC of your child's care plan before your child's first day of school). ___ Severe Allergy ___ Asthma ___ Diabetes ___ Other: ___

Allergies- Please list allergies and reactions:

Foods: _____	Typical Reaction: _____
Drugs: _____	Typical Reaction: _____
Other: _____	Typical Reaction: _____
My child has an Epi-Pen ___ Yes ___ No	Are any of the allergies life-threatening? _____

My child does not tolerate the following:

Foods: _____	Typical Reaction: _____
Other: _____	Typical Reaction: _____

