NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

| Child's Name: | Child's date of birth: |
|---|---|
| Name of the child's health care provider: | ☐ Physician<br>☐ Physician Assistant<br>☐ Nurse Practitioner |

**Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.**

**Identify the program staff who will provide care to this child with special health care needs:**

| Name | Credentials or Professional License Information* |
|---|---|
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This is a double-sided form

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***Continued***

**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**

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**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

| Provider/Facility Name: | Facility ID Number: | Facility Telephone Number: |
|---|---|---|
| Authorized child care provider's name (please print): | | Date: |
| Authorized child care provider's signature: | | |

**Signature of Parent or Guardian:**

| | Date: |
|---|---|
| | |