SPNDS Special Care Plan form

Full Name of Child: Birth date:
Allergies □ No □ Yes (if yes, please specify allergy and attach medical documentation from physician)
Medical/behavioral concerns:
Needed Accommodations (Please describe accommodations and why it is necessary)
Medications to be Given at Home: □ No □ Yes (if yes, please list medications)
Special Equipment/Medical Supplies: □ No □ Yes (if yes, please specify)
Special Staff Training Needs: □ No □ Yes (if yes, please specify)
Special Emergency Procedures: □ No □ Yes (if yes, please specify)
Outside support staff Working with This Child: □ No □ Yes (if yes, please list and indicate roles)
Additional Information/Comments on Child, Family, or Medical Issues
Parent/Legal Guardian Signature Date