

## **SPNDS Special Care Plan form**

Full Name of Child:	В	Birth date:	
Allergies □ No □ Yes	(if yes, please specify allergy and attach medical docur	mentation 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 W	orking with This Child: $\square$ No $\square$ Yes (if yes, please list and i	indicate roles)	
Additional Information/Comments on Child, Family, or Medical Issues			
Parent/Legal Guardian S	ignature	Date	