

INDIVIDUALIZED CHILD CARE PLAN

Excelsior Covenant Preschool ♦ preschool@excelcov.org ♦ 952-474-1684

STUDENT NAME: _____ DOB: _____

Parent/Guardian #1 _____ Cell phone: _____

Parent/Guardian #2 _____ Cell phone: _____

Specific health care needs and/or diagnosis: _____

Primary health provider's name: _____ Phone: _____

Consulting specialist name: _____ Phone: _____

TREATMENT PLAN DEVELOPED TO MEET THE INDIVIDUAL CHILD'S NEEDS:

Describe the child's special needs during group care: _____

Does the child require any specific accommodations in group child care? _____

(Sleeping, diapering, toileting, feeding, medications, special equipment, in the gym, on the playground). Describe specific accommodations needed: _____

Describe the child's present functional level and skills: _____

Are there any activity restrictions? _____

OTHER INFORMATION: _____

Consulting specialist's signature: _____ Date: _____

Consulting specialist's title: _____

Parent/guardian signature: _____ Date: _____

Health care provider's signature (required if the child has been determined by a licensed physician, psychiatrist, licensed psychologist, or licensed consulting psychologist as having a special need relating to physical, social, or emotional development):

Health care provider's signature: _____ Date: _____

Copy of IEP attached: yes _____ no _____