# WCMCA Special Care Plan

Child Name: _____ D.O.B.: _____

WCMCA Head Start- _____

This Special Care Plan identifies a health need, and the parent or guardian has requested the program to modify services and/or administer medication to address the need, whether temporary or chronic.

- Examples: Bronchitis, Reactive Airway Disease, limited mobility, a need for an inhaler *not* related to asthma or an allergy, special instructions after a medical procedure, etc.

Description of need:

How is this need best accommodated? List instructions and any special equipment.

Is medication required to accommodate? ☐ Yes ☐ No

**Note:** *If medication is required while the child is at Head Start, attach the physician's instructions or care plan and an Authorization to Administer Medication form.*

Do staff members need special training? ------ **If yes, please specify:**

Are there instructions from a medical provider? ☐ Yes (*please attach)* ☐ No

**I agree that the above plan will meet the needs of my child during Head Start programming, and I will notify the program if there are any changes from the healthcare provider or need.**

Parent/Guardian Signature:

_____ Date: _____

**I agree to follow this care plan and notify the parent/ guardian of any problems or concerns immediately.**

Family Education Specialist's Signature:

_____ Date: _____