NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

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

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

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

iollowing health care plan to meet the indivi	idual fieeds of.
CHILD NAME:	CHILD DATE OF BIRTH:
NAME OF THE CHILD'S HEALTH CARE PROVIDE	R: Physician
	☐ Physician Assistant
	☐ Nurse Practitioner
	his child and the plan of care as identified by the parent and the child's formation completed on the medical statement at the time of enrollment or
Identify the caregiver(s) who will provide	e care to this child with special health care needs:
Caregiver's Name	Credentials or Professional License Information (if applicable)

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Describe any additional training, procedures or competencies the caregiver 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.

who will provide this training	J .		
identified to provide all treat plan are familiar with the chi	close collaboration with the child's parent and tements and administer medication to the child ild care regulations and have received any add such treatment and medication in accordance with the collaboration in accordance with the collaboration in accordance with the collaboration in accordance with the child's parent and medication in accordance with the child's parent and the child is the child in the child is the child is the child in the child is the chi	listed in the specialized individual health of itional training needed and have demonstra	care
PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:	
CHILD CARE PROVIDER'S NAM	ME (PLEASE PRINT):	DATE:	
CHILD CARE PROVIDER'S SIG	NATURE:	I	
l agree this Individual Healt	h Care Plan meets the needs of my child.	Yes 🗌 No 🗌	
the strategies the program i	rmation about my child's allergy with all progra implements to keep my child from being expos al reminders that may result in the disclosure Yes ☐	sed to known allergen(s). I acknowledge th	ese
Signature of Parent:			
x		DATE:	