TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska
Mailing: P.O Box 25500, Juneau, AK 99802• Physical 9095 Glacier Highway • Juneau AK 99801
Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

SPECIAL CARE PLAN

Child's Name: Date of Birth:	Center: Child's Current Weight:
Parent/Guardian's Name Cell/Home/Work Phone #	Signature for Consent*
Emergency Contact Person (Name/Relationship) Cell/Home/Work Phone #	*Consent for health care professional to communicate with my child's teacher provider to discuss information relating to this care plan.
Primary Health Care Professional Emergency Phone #	Authorization for Release of Information Form completed? □ N/A □ Yes □ No
Specialty Provider Emergency Phone #	Emergency Information Form for Children With Special Needs completed? □ N/A □ Yes □ No
Specialty Provider Emergency Phone #	Specialty Care Plan(s) completed? □ N/A □ Yes □ No
Allergies □ Yes □ No (If yes, please specify)	
Medical/Behavioral Concerns	
Requested Accommodations (Please check box and describe necessary accommodation needed due to medical condition? Attach additional pages if needed to provide complete information.) □ Diet/Feeding □ Classroom Activities □ Nap/Sleep	 □ Toileting □ Outdoor or Field Trips □ Transportation
Recommend Treatment	
Medication to Be Given at Head Start □ No □ Yes Provide specific name of medications on the Permission to Administer Medication Form on file or submitted if applicable: ___________________	If yes, do you have a current Permission to Administer Medication on file? □ Yes □ No
Medication Given at Home □ No □ Yes	If yes, please list in additional information section or attach info.

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SPECIAL CARE PLAN

Special Equipment/Medical Supplies □ No □ Yes	If yes, please list in additional information section or attach info.
Special Staff Needs □ No □ Yes	If yes, please list in additional information section or attach info.
*Special Emergency Procedures & Plan □ No □ Yes If yes, please explain in this section or attach info:	
Other Specialist(s) Working With This Child □ No □ Yes Is specialized training required? If so, please describe.	If yes, please list in additional information section or attach info.
____ **Parent/Guardian Signature Acknowledging Review of Above Information**	____________________ **Date**
Clinic:______________________________ ____ **Health Care Professional (Print Name)**	Date:______________ ______________________________ **Health Care Professional's Signature**
Lead Teacher Name: (LT) Signature: ____ Review Date:__________________________Updated plan (check one): Yes________No__________	

Mail or fax a copy of physical & screenings to Head Start:
Attention: *Child Health & Safety Coordinator*