



TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

Mailing: 9097 Glacier Hwy, Juneau, AK 99801 • 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:	Center:
Date of Birth:	Child's Current Weight:
Parent/Guardian's Name	Signature for Consent* <hr/> *Consent for health care professional to communicate with my child's teacher provider to discuss information relating to this care plan.
Cell/Home/Work Phone #	
Emergency Contact Person (Name/Relationship)	
Cell/Home/Work Phone #	
Primary Health Care Professional	Authorization for Release of Information Form completed?
Emergency Phone #	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty Provider	Emergency Information Form for Children With Special Needs completed?
Emergency Phone #	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty Provider	Specialty Care Plan(s) completed?
Emergency Phone #	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> 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.)	
<input type="checkbox"/> Diet/Feeding	<input type="checkbox"/> Toileting
<input type="checkbox"/> Classroom Activities	<input type="checkbox"/> Outdoor or Field Trips
<input type="checkbox"/> Nap/Sleep	<input type="checkbox"/> Transportation
Recommend Treatment	
Medication to Be Given at Head Start <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, do you have a current Permission to Administer Medication on file? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide specific name of medications on the Permission to Administer Medication Form on file or submitted if applicable: _____	
Medication Given at Home <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list in additional information section or attach info.



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Special Equipment/Medical Supplies <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list in additional information section or attach info.
Special Staff Needs <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list in additional information section or attach info.
*Special Emergency Procedures & Plan <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain in this section or attach info:	
Other Specialist(s) Working With This Child <input type="checkbox"/> No <input type="checkbox"/> Yes Is specialized training required? If so, please describe.	If yes, please list in additional information section or attach info.
<hr/> 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