STRONG START
EARLY CARE & EDUCATION
Inquisitive minds. Confident kids.

Individual Plan of Care

Name of child:_____ Date of plan:_____

Condition for which special care is needed_____

Primary Physician:_____Telephone number:_____

Additional Health Care Providers, Educational Programs, or Therapy Services:

I give permission for the Director of Strong Start to contact the above providers for information regarding the treatment and education of my child. ____Yes ____No

Accommodations, supports, restrictions, or modifications required for my child:

Medication, treatment or management instructions when child is in the center:

IEP/IFSP on file: ____Yes ____No Adaptive Equipment:_____

Training for management required:

Other information:

_____ _____
Director Signature Parent Signature

_____ _____
Date Date

Health Care
Provider:_____

_____
Date