Early Head Start
UTRGV

UTRGV - PSJA - EHS - CC
Partnership Program

Health Care Plan for Special Needs

Accommodation Form

Child's Name:	**D.O.B:**	**Center:**
Name of Child's Health Care Provider:		**Phone:**
Describe the special healthcare need(s):		
Signs/Symptoms for need of treatment(s):		
Triggers if known:		
Description of Treatment:		
Describe any additional training, procedures, or competencies that staff will need to carry out the healthcare plan with child with special healthcare need(s):		
Health care professional signature:	**Print name of HCP:**	
Address/phone:	**Date:**	

Original: Family File Copy: Parent Copy: Medication/Emergency Binder Copy: Teaching Staff/Child Portfolio
Copy: with medication