

# YMCA of Greater Seattle

## Individual Care Plan

*Plan must be updated annually or when there is a change in the child's accommodation or care needs.*



Thank you for filling out this form to help us best serve your child in our Y programs. Please fill out the sections required for your child's behavior support and/or accommodation needs.

### SECTION 1 – REQUIRED

Child's Full Name	Today's Date
Parent's/Guardian's Name	Phone Number
Primary Health Care Provider	Phone Number
Specialist (if applicable)	Phone Number
Specialist (if applicable)	Phone Number

### SECTION 2 – REQUIRED FOR CHILD WITH BEHAVIORAL & MEDICAL CONDITIONS (Food Allergy skip to section 3, Environmental Allergy skip to section 4)

#### CHILD'S ACCOMODATIONS

Diagnosis, if know:
Known Symptoms and Triggers:
Describe activity, behavioral, or environmental modifications that are needed for the child:
Please provide any additional information that you feel would be helpful for the YMCA team to be aware of:
<i>For special dietary needs due to a health condition – must obtain written instructions from a child's health care provider (see page 3)</i>

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### EMERGENCY RESPONSE PLAN

List the steps and procedures the staff should perform during an emergency related to your child's accommodations:

### SUGGESTED TRAINING FOR STAFF

List suggested special skills training/education for the program staff:

### SUPPORTING DOCUMENTATION

Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 and 110-301-0300 requires the provider to have supporting documentation of child's special needs provided by the child's licensed or certified:

- (i) Physician or physician assistant
- (ii) Mental health professionals
- (iii) Educational professional
- (iv) Social worker with a bachelor's degree or higher with specialization in the individual child's needs: or
- (v) Registered nurse or advanced registered nurse practitioner

### SIGNATURE

Parent or Guardian Signature	Date
Y Staff Signature	Date
Health Care Provider Signature (optional)	Date
<b>This section to be completed by child's parent or guardian, if applicable:</b>	
I hereby give permission for _____ to provide services to my child at this program. (name of visiting health professional or specialist)	
Parent or Guardian Signature	Date