YMCA OF SNOHOMISH COUNTY
INDIVIDUAL CARE PLAN

This form will be completed and signed by parent/guardian and Program Director, periodically reviewed and updated as necessary and used to develop a plan for reasonable accommodation, including to provide staff with the training necessary to implement the plan.

A child with a potentially life-threatening condition such as a severe food allergy or asthma may not be registered for the program until all forms, and parent/physician permission forms are returned fully completed. For the child's safety, upon enrollment all parent-provided supplies such as emergency medication noted in the plan or required special foods must be received at the time of drop-off or the child will not be allowed to stay.

FOR ALL OTHER CONDITIONS, AN INDIVIDUAL CARE PLAN IS NOT REQUIRED WHEN THE CHILD'S PARENT(S) BELIEVE THE CHILD MAY FULLY PARTICIPATE IN THE PROGRAM SUCCESSFULLY WITHOUT ANY SPECIAL ACCOMMODATIONS. The parent and / or YMCA staff may request a review to determine if a plan should be developed at a later date when the parent or YMCA staff determine that the child's participation in the program is at a less than safe, successful level.

In the spaces below indicated by an asterisk*, list any symptoms indicative of non-potentially life threatening conditions and note to refer to Emergency Action Plan, where these steps will be listed specifically for your child's life-threatening condition as directed by his/her health care provider.

CHILD'S NAME	**DESIRED START DATE**

LIST ALL CONDITIONS THAT AFFECT YOUR CHILD & MAY PREVENT SUCCESS IN THE PROGRAM OR REQUIRE ACCOMMODATIONS

CONDITION / DIAGNOSIS: LIST A-Z WHEN MORE THAN ONE & REQUEST SUPPLEMENTAL PAGE IF MORE SPACE WILL BE NECESSARY

INDICATE CURRENT PROFESSIONAL INVOLVEMENT / SUPPORT: (check all that apply)

☐ Health Care Provider	☐ Homeopath/Naturopath	☐ Psychological Services	☐ Occupational Therapy
☐ Physical Therapy	☐ Speech Therapy	☐ Teacher/Instructional Aid	☐ School Counselor
☐ Medical Specialist	☐ Other(s):		☐ Does not apply

INDICATE AND DESCRIBE THE LEVEL OF ACTIONS/SKILLS YOUR CHILD NEEDS HELP WITH: (check all that apply)

☐ **COMMUNICATION** – ability to verbally express self and respond appropriately ☐ N/A - communicates well

☐ **MOBILITY** – ability to walk stand, or otherwise move about with or without assistance ☐ N/A – no assistance needed

☐ **SELF-HELP** – ability to self-feed, dress, toilet and recognize and avoid danger ☐ N/A – able to help self

☐ **INTELLECTUAL** – ability to choose/stay with an activity, handle transition/change in routine, understand/comply w/safety rules
☐ N/A – stay engaged, transition and be safe

☐ **SOCIAL/EMOTIONAL** – ability to share, take turns, maintain relationships, express emotion appropriately and control impulses
☐ N/A – stay engaged, transition and be safe

☐ **OTHER CONCERN(S)**: ☐ N/A – no (other) concerns

DESCRIBE what help indicated above is needed and provide suggestions for success:

* LIST EXPECTED SYMPTOMS OR BEHAVIORS DUE TO YOUR CHILD'S CONDITION AND RECOMMENDED RESPONSES BY STAFF	
SYMPTOMS OR BEHAVIORS	**STAFF TO RESPOND BY**

* LIST EXPECTED SYMPTOMS / BEHAVIORS THAT MAY INDICATE CAUSE FOR CONCERN AND REQUIRED RESPONSES BY STAFF	
SYMPTOMS OR BEHAVIORS	**STAFF TO RESPOND BY**

WHAT, IF ANY TRAINING/SKILLS WILL STAFF NEED TO RECOGNIZE & RESPOND APPROPRIATELY TO THE SYMPTOMS/BEHAVIORS?
With your child's previous experiences in group environments, what recommendations, requests or suggestions do you have for staff in making appropriate accommodations for your child's individual need? Please describe in detail, what you believe will best enable your child to participate successfully in the YMCA child care program.

COMPLETE THIS PORTION WITH YOUR YMCA PROGRAM DIRECTOR

Mutually agreed upon Individual Care Plan/Responsibilities:

Parent will:

YMCA staff will:

Child will:

The Emergency Action Plan must be completed when the child has a condition or potential for a reaction that will require immediate medical treatment as indicated in the Individual Care Plan. I understand that this Individual Care Plan may be reviewed as necessary at which time changes may or may not be deemed necessary.

☐ **SUPPLEMENTAL PAGE IS ATTACHED**

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of YMCA Program Director Date

_____ _____
Signature of YMCA Site Coordinator Date

REVIEWS (Date/Initial) - Reviewed: 1) PD_____ P/G _____ 2) PD _____ P/G: _____

FOR OFFICE USE ONLY

Application Date: _____ Approval Date: _____ Comments: _____

YMCA OF SNOHOMISH COUNTY
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SUPPLEMENTAL PAGE

CHILD'S NAME	CONDITION REQUIRING PLAN

INDICATE SECTION(S) CARRYING OVER FROM

☐ LIST / DESCRIPTION OF CONDITION / DIAGNOSIS
☐ SYMPTOM / REQUIRED RESPONSE
☐ DESCRIPTION OF ASSISTANCE REQUIRED BY CHILD
☐ TIPS / INSTRUCTIONS FOR STAFF

CONTINUE:

☐ LIST / DESCRIPTION OF CONDITION / DIAGNOSIS
☐ SYMPTOM / REQUIRED RESPONSE
☐ DESCRIPTION OF ASSISTANCE REQUIRED BY CHILD
☐ TIPS / INSTRUCTIONS FOR STAFF

CONTINUE:

☐ LIST / DESCRIPTION OF CONDITION / DIAGNOSIS
☐ SYMPTOM / REQUIRED RESPONSE
☐ DESCRIPTION OF ASSISTANCE REQUIRED BY CHILD
☐ TIPS / INSTRUCTIONS FOR STAFF

CONTINUE:

Parent Signature ______________________________ Date __________ Director Initials ________ Date __________