YMCA OF THE EAST BAY DOWNTOWN BERKELEY
DAY CAMPS
2001 Allston Way ● Berkeley ● CA ● 94704
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SPECIAL CARE NEEDS

Provider Instructions - Special Care Needs

Child's Name	Date of Birth	Age	Responsible Person (Name)	Relationship to child

Address	City	Zip	Phone Number

TO BE FILLED OUT BY HEALTH CARE PROVIDER:

1. Description of condition(s): (include description of difficulties associated with each condition)
2. Medical Diagnosis
3. Any known allergies to food and/or medications
4. Medications to be kept on site/instructions
5. Treatments to be administered
6. Mobility/motor/activity: (restrictions/safety)
7. Communication Needs: (vision, hearing, speech and language)
8. Learning/Cognitive: (abilities and limitations)
9. Social/Emotional: (skills and needs)
10. Self-Help: (elimination, feeding)
11. Please list any signs and symptoms which require contacting a physician:
12. Are there any other recommendations you have given this parent? Is there any future follow-up care this child needs that our staff can assist this family with?

I authorize Head Start and the Physician to release and exchange information from this form for 1 year from the date of provider completion of this form.

The Health Care Provider _____has authorized the parent/guardian _____ to train YMCA staff to administer the required medication to their child. The parent/guardian has demonstrated how to use all required medication to teaching staff.

Parent/Guardian Signature: _____ **Date**: _____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name (Please Print): _____ License Number: _____

Address: _____ City: _____ Zip:_____

Phone: _____ Fax: _____