SACC Special Needs Planning Form*

STUDENT: _____________________________ GRADE: _____ CHILDCARE SITE: ____________

RETURNING CHILD? YES ☐ NO ☐ SPECIAL NEEDS: ____________________________

If yes, please describe any changes over the summer: ____________________________________________

Please list any suggestions or strategies that would be beneficial for staff to implement based on prior successes:
________________________________________________________________________________________

CHILDCARE SCHEDULE:

BEFORE CARE: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐
AFTER CARE: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐

This form will be used to help childcare staff understand and accommodate for your child’s special needs.

- Please describe any necessary support for your child’s participation in childcare.
- Please be aware that attendance may not be possible until accommodations are in place.

Communication: (e.g. AT devices, communication system, etc.)

Does your child use any special communication technology? YES ☐ NO ☐
If yes, please describe: _________________________________________________________________

Does your child need an interpreter/assistive device? YES ☐ NO ☐

Furniture/Equipment: (e.g. chairs or sensory seating, walker, etc.)

Does your child need/use any special furniture or equipment? YES ☐ NO ☐
If yes, please describe: _________________________________________________________________

Behavioral: (e.g. token system, behavioral plan tools, sensory tools, etc.)

When angry, my child will ________________________________________________________________
My child has difficulty ________________________________________________________________
When upset, my child responds best to ______________________________________________________
My child will need assistance with the following:
☐ dressing ☐ going to the bathroom
☐ remembering to use the bathroom ☐ understanding/following simple directions
☐ communication ☐ other: ____________________________

Academic: (e.g. supports, materials & methods)

Does your child receive any academic support? YES ☐ NO ☐
☐ OT ☐ PT ☐ Speech ☐ TA ☐ TC_______________
☐ Self-contained classroom

Parent Name: _____________________________ Phone: ___________ Email: __________________________

*Please return at least 4 weeks before you want your child to attend childcare!
Dear Parent/Guardian,

Parents of students with food allergies are required to provide a daily snack from home. If your child has very specific allergies, and this written agreement is in place, SACC may be able to provide a portion of the daily snack. This form specifies to the Supervisor what foods Child Care may provide and what foods the parent will provide. Snack will not be provided until this form is completed, signed by a parent, submitted to the Child Care Site Supervisor and authorized by a Community Education Administrator.

Child’s Name: _________________________ Grade: ______ School: ______________

My child is allergic to: ____________________________________________________

My child may eat the following foods in childcare (circle YES or NO):

YES NO Fruits and vegetables including juice, applesauce, and fruit cocktail, except:

YES NO Milk, yogurt, cream, pudding and any other milk products

YES NO Eggs, meat, poultry, fish, beans

YES NO Syrup, jam, jelly and honey

YES NO Any and all processed dry goods, including bread, cereal, rice, pasta, crackers, bagels, pretzels, popcorn, rice cakes, and granola bars. (No exceptions to this category are permitted, since exceptions would require staff to read food labels.) Students with nut allergies cannot be served any foods from this group.

☐ I agree that my child can be served the foods indicated above in childcare.

☐ I understand the School Age Child Care Staff will NOT read labels to accommodate my child.

☐ I understand that if my child has a food allergy, my child will not be served a snack until this form is signed.

☐ I opt to provide my child’s snacks from home. Snacks may be stored in childcare. All foods must be labeled with your child’s name and allergy on the package.

☐ I understand my child will only be provided the foods I have indicated above.

Parent Name:_________________________________________________________ Phone:________________________

Parent Signature:____________________________________________________ Date:_______________________

Administrator’s Signature:____________________________________________ Date:_______________________
Ann Arbor Public Schools
Medication Administration Form*
Authorization for the Administration of Medications by
School Age Child Care Personnel

The Ann Arbor Public Schools require a physician’s written order and the parent’s or guardian’s written authorization for administration of all medications, including over-the-counter medications.

*Note: An equivalent form from your child’s doctor’s office may be used, as long as it is also signed and dated by a parent.

PHYSICIAN’S ORDER FOR MEDICATION ADMINISTRATION

Name ___________________________________________ Date _______________
Address ___________________________________________ Birthdate ____________
Diagnosis ___________________________________________

Name of medication(s) ___________________________________________

Time(s) of administration and dosage ________________________________________

Relevant side effects, if any ________________________________________________

Other suggestions _________________________________________________________

The length of time that the medication may be administered shall be one school year, from September through August. All medication authorizations must be renewed at the start of each school year.

Physician Signature ________________________________________________
Address _____________________________________________________________

I hereby request that my child be administered the above medication(s) by childcare/camp personnel. I understand that the medication(s) will be administered as directed by the above named physician and that each medication must come in its original container. I will notify the school in writing if an authorized medication is to be discontinued. If the administration of an authorized medication needs to be otherwise changed, I with resubmit an Authorization for the Administration of Medication form with physician signature.

Parent/Guardian Signature ____________________________________________ Date ____________
ACTION PLAN (One per child)

Note: If your child has an Action Plan from a doctor's office, you may use that instead.

Child’s Name: ______________________________ Childcare site: ________________
Child’s condition/symptoms: __________________________________________________
Medications: ______________________________________________________________
Location of emergency medication(s): __________________________________________
Allergies: _________________________________ ________________________________
Preferred hospital: __________________________________________________________________

In the event of an episode, childcare staff should follow these procedures:

1. If ____________________________________________________________________________
then:

   2. If ____________________________________________________________________________
then:

   3. If ____________________________________________________________________________
then:

Parent/Guardian #1: ______________________________________________________________
Cell: ______________ Work: ______________ Other: ______________________________
Place of employment: __________________________________________________________________

Parent/Guardian #2: ______________________________________________________________
Cell: ______________ Work: ______________ Other: ______________________________
Place of employment: __________________________________________________________________

Parent/Guardian signature: ___________________________ Date: __________