

Care Plan

Date of Review:

Name: Stacey

D.O.B.:

Family:

Address:

Home Telephone:

Mobile Phone:

Emergency Contacts:

Condition: Global Developmental Delay

How does this present? poor motor control

Medical Needs and Protocols:

Manual Handling: Yes

Current Home /School Medications, Dosage and Times: none

Where School Medication is kept/ Date Expired:

Doctor Contact Details:

Feeding Requirements: chopped
assisted

Feeding Times/ Dosage if applicable:

Feeding Likes/ Dislikes: likes yoghurts, mashed potato, chocolate/ dislikes fish

How does the child indicate this?: turns head away

Toileting: Nappies: yes
aided

Communication:

Limited communication: reaches out for what she wants, cries

How does the child indicate- Happy: gurgling noises, laughing

Distressed: cries

Level of Comprehension: Poor

Any Other Information: