

## **Medically Complex Foster Care Child-Specific Training**

Please answer each question that applies in detail.

Date of child-specific training: \_\_\_\_\_

### **SECTION 1**

Child's name:

Child's date of birth:

Name of individual receiving training:

Reason for child-specific training (select one):

New placement

New medical condition

Respite

Babysitting

Other (list):

### **SECTION 2**

Please list the child's medical diagnoses and the treatment plan for each:

**Additional information for a child with diabetes, seizures, or a feeding tube:**

Training provider signature  
(Credentials if medical provider)

Date signed

Individual receiving training signature

Date signed

**SECTION 3 (Complete only if applicable)**

If the child has a diagnosis of diabetes (type 1 or 2), seizures, or a feeding tube, please fill out the corresponding section.

**Diabetes**

Frequency of glucose checks/continuous glucose monitoring:

Carb to insulin ratio & correction factor:

Nighttime insulin dose:

Plan for hyperglycemia (check ketones, drink water, etc.):

Plan for hypoglycemia (juice, glucose tablets, etc.):

**Seizures**

Typical presentation of child's seizure:

Anti-seizure medication (dose/frequency):

Seizure action plan (emergency seizure medication/instructions):

**Additional info if the youth is diabetic, has seizures, or a feeding tube:**

**G-tube (includes NG and GJ-tubes)**

Feeding/formula (including free water):

Frequency and rate of feedings:

Training provider signature  
(Credentials if medical provider)

Date signed

Individual receiving training signature

Date signed