



Special Treatment Protocol

Child's Full Name: _____ Team: _____ Program: _____

Need for Protocol:

Seizure: Type(s) _____ Frequency _____ Length _____

Allergies: Type (s) _____

Feeding Tube: _____

Other: _____

Warning Signs: _____

What typically happens: _____

Protocol for Bell Center staff (please be specific):

Steps for Plan A: _____

Steps for Plan B (if A is ineffective): _____

Parent's Name: _____ Home Number: _____

Work Number: _____ Cell Number: _____

Other emergency contact (family, guardian, friend) if parent cannot be reached:

Name: _____ Phone Number: _____

Parent Signature: _____ Date: _____