**SCOPE EDUCATION SERVICES**
**100 Lawrence Avenue, Smithtown, NY 11787**

Dear Parent/Guardian,

Thank you for registering your child with SCOPE Education Services. After reviewing your child's registration, it has come to our attention that your child may have a medical need at SCOPE. If your child will **not** require medication at the SCOPE program, it is necessary for you to please complete and return **Form A** (enclosed).

SCOPE is authorized to administer oral, inhaled medication and epinephrine auto-injector medication on an emergency basis to children diagnosed with asthma and/or allergy. **SCOPE cannot take possession of any medication, and your child cannot start the program until you meet with the SCOPE Program Supervisor to review your child's specific needs and bring the following:**

1. **Individual Health Care Plan** completed in advance by you and reviewed and signed by the SCOPE Program Supervisor. You may use the asthma and/or allergy health care plans found in the packet or create your own using the blank form provided.
2. **Written Medication Consent Form** completed and signed by:
    - Health Care Provider – # **1-18** (and # **33-36** if necessary). The Health Care Provider must clearly state the exact name and strength of the medication (# **4)** and clearly state the symptoms that necessitate the use of medication (# **7B**)
    - Parent/Guardian – # **19-23**
    - SCOPE MAT certified Staff – # **24-30**
3. **Medication(s)**: All medication must be in the original box with the original pharmacy label. Over the counter medication must be labeled with the child's name. Medication samples cannot be accepted. **The expiration date of the medication should be no less than six months from your child's start date**.

The SCOPE Program Supervisor will contact you before the start of school to confirm a date and time to meet with you prior to the first day of school to collect and review the above items with you. In most cases the date will be the day before the first day of school between the hours of 9:00 AM and 10:00 AM (before school program) or between 5:00 PM and 6:00 PM (after school program**). Please note that if the forms or medication are incorrect or incomplete, SCOPE cannot accept or administer the medication.** Please be assured that information regarding your child will be kept confidential.

Thank you for choosing SCOPE Child Care.

Sincerely,

Michael J. O'Brien

Michael J. O'Brien
Associate Director for Student Services

MAT Medical/Fall-7/12

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

| Child's Name: | Child's date of birth: |
|---|---|
| Name of the child's health care provider: | ☐ Physician<br>☐ Physician Assistant<br>☐ Nurse Practitioner |

**Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.**

**DIAGNOSIS:**

**SYMPTOMS:**

**Other symptoms:**

**TREATMENT:**

**Other treatments:**

**Identify the program staff who will provide care to this child with special health care needs:**

| Name | Credentials or Professional License Information* |
|---|---|
| Rosalie Buffalino, RN | License # 298810-1; exp. date: - June 2014 |
| | CPR, First Aid, and Medication Administration Training (MAT) |
| | CPR, First Aid, and Medication Administration Training (MAT) |

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

*Continued*

**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**

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| Most staff are trained in CPR and First Aid, and some are trained to give medication (MAT). |
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**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

| Provider/Facility Name: SCOPE @ | Facility ID Number: | Facility Telephone Number: |
|---|---|---|
| Authorized child care provider's name (please print): | | Date: |
| Authorized child care provider's signature: | | |

**Signature of Parent or Guardian:**

| | Date: |
|---|---|
| | |

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

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| Child's Name: | Child's date of birth: |
|---|---|
| Name of the child's health care provider: | ☐ Physician<br>☐ Physician Assistant<br>☐ Nurse Practitioner |

**Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.**

**DIAGNOSIS: Allergy to**

**Symptoms: Mouth - Itching, tingling, metallic taste; swelling of lips, tongue, mouth**
**Skin - Itchy rash, hives, swelling of lips, eyes, face, or extremities**
**Abdominal - Nausea, cramping, vomiting, diarrhea**
**Throat - Hoarseness, hacking cough, tightening and/or swelling of throat**
**Lung - Shortness of breath, repetitive coughing, wheezing**
**Heart - Fainting, paleness, or blueness of lips or fingernail beds**
**Other -**

**Treatment: 1) Avoid known allergens**
**2) At the first sign of symptoms, notify parent then administer benadryl if ordered**
**3) For a more severe allergic reaction, administer epi-pen or epi-pen jr. if ordered**
**4) At the first sign of a severe allergic reaction, call the local fire department or 911 for emergency response, then notify parent.**
**5) Staff member must accompany child on ambulance if family has not arrived.**
**6) If epi-pen is used, it must be sent to the hospital with child.**

**Identify the program staff who will provide care to this child with special health care needs:**

| Name | Credentials or Professional License Information* |
|---|---|
| Rosalie Buffalino, RN | License # 298810-1; expiration date- 6/2014 |
| | CPR, First Aid, and Medication Administration Training (MAT) |
| | CPR, First Aid, and Medication Administration Training (MAT) |

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

*Continued*

**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**

Most staff are trained in CPR and First Aid, and some are trained to give medication (MAT).

**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

| Provider/Facility Name: SCOPE @ | Facility ID Number: | Facility Telephone Number: |
|---|---|---|
| Authorized child care provider's name (please print): | | Date: |
| Authorized child care provider's signature: | | |

**Signature of Parent or Guardian:**

| | Date: |
|---|---|
| | |

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

| Child's Name: | Child's date of birth: |
|---|---|
| Name of the child's health care provider: | ☐ Physician<br>☐ Physician Assistant<br>☐ Nurse Practitioner |

**Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.**

**DIAGNOSIS: Asthma**

**Symptoms: rapid breathing, wheezing, open mouth breathing, flaring nostrils, grunting**
**face reddened, paled, or swollen, dark circles under the eye**
**persistent cough, complaining of chest pains or tightness in chest**
**restlessness, agitation, difficulty eating, talking, drinking or playing, fatigue**
**grey or blue fingernail beds or lips**
**Other:**

~~**Treatment: 1) Avoid known triggers. (circle or check all that apply)**~~

| | | |
|---|---|---|
| grass | tree pollen | flowers |
| dust | smoke | strong odors |
| mold | excitement | exercise |
| animals | illness/cold | weather changes |

**2) Notify parent and administer medication if ordered for symptoms above.**
**Encourage child to rest and take slow, deliberate breaths.**
**3) If no improvement in 15 - 20 mins, seek emergency care by calling 911 or local fire department. A staff member must accompany child if no family is present.**

**Identify the program staff who will provide care to this child with special health care needs:**

| Name | Credentials or Professional License Information* |
|---|---|
| Rosalie Buffalino, RN | License # 298810-1; expiration date -6/2014 |
| | CPR, First Aid, and Medication Administration Training (MAT) |
| | CPR, First Aid, and Medication Administration Training (MAT) |

OCFS-LDSS-7006 (Rev 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

*Continued*

**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**

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| Most staff are trained in CPR and First Aid, and some are trained to give medication (MAT). |
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**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

| Provider/Facility Name: SCOPE @ | Facility ID Number: | Facility Telephone Number: |
|---|---|---|
| Authorized child care provider's name (please print): | | Date: |
| Authorized child care provider's signature: | | |

**Signature of Parent or Guardian:**

| | Date: |
|---|---|
| | |

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

## LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

*(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)*

| 1. Child's first and last name: | 2. Date of birth: | 3. Child's known allergies: |
|---|---|---|
| 4. Name of medication (including strength): | 5. Amount/dosage to be given: | 6. Route of administration: |

7A. Frequency to be administered: _____

***OR***

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

***AND/OR***

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

***AND/OR***

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

| 14. Date prescriber authorized: | 15. Date to be discontinued or length of time in days to be given *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*: |
|---|---|
| 16. Prescriber's name (please print): | 17. Prescriber's telephone number: |

18. Licensed authorized prescriber's signature:

X

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# WRITTEN MEDICATION CONSENT FORM

## PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm):

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name)

| 21. Parent or legal guardian's name (please print): | 22. Date authorized: |
|---|---|
| | |

23. Parent or legal guardian's signature:
X

## DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

| 24. Provider/Facility name: | 25. Facility ID number: | 26. Facility telephone number: |
|---|---|---|
| | | |

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

| 28. Authorized child care provider's name (please print): | 29. Date received from parent: |
|---|---|
| | |

30. Authorized child care provider's signature:
X

## ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:
X

## LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:
X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:
X

# SCOPE FORM A

**To the Parent/Guardian of:** _____ **Date:** _____

**SCOPE Student ID#:** _____ **Program Site:** _____

**From:** _____ **@ (631) 360-0800 ext.** _____

**The SCOPE Registration Application you completed for your child indicates the following:**

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**Please note that if your child does <u>not</u> require medication at SCOPE, this form must be completed and received <u>before</u> your child can start SCOPE. If your child will require medication at SCOPE, the attached forms must be completed and returned to SCOPE with the medication before your child can start SCOPE.**

**My child,** _____**, will not require the medication during the SCOPE program.**

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

**PLEASE FAX YOUR COMPLETED FORM TO: (631) 360-0356 :**

**SCOPE STUDENT SERVICES**
**100 LAWRENCE AVENUE**
**SMITHTOWN, NY 11787**

**THANK YOU FOR YOU PROMPT ATTENTION**