INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PLAN FORM FOR CHILDREN WITH ALLERGIES AND NO MEDICATIONS

You indicated on your child's registration that your child has an allergy, and <u>you are not providing</u> SCOPE with any medications.

Per OCFS regulations, you must complete the attached **"Allergy To"' Individual Health Care Plan** as follows and a **Form A** (forms below):

- **Complete on page 1 of the Individual Health Care Plan**
  - Child's information, legal name, date of birth
  - Heath Care provider name and discipline MD, PA, NP, etc.
  - School District
  - Site (SCOPE Program Location)
  - Specific allergies

- **Complete on page 2 of the Individual Health Care Plan**
  - In the "Most staff is trained in CPR & First Aid" Section: indicate if any specialized training is necessary for your child's condition
  - "List Any Restrictions" Section (write none if there are no restrictions)
  - ***For food allergies only***, you must state specifically which SCOPE snacks are approved for your child, or if all SCOPE snacks are approved, or if no SCOPE snacks approved. All SCOPE snacks are peanut and tree nut free. Contact SCOPE if you need additional information about our snacks.
  - Parent/Guardian signature and date

*** Please do not combine multiple diagnoses on the Individual Health Care Plan.***

- Please complete the following information on the **Form A**
  - Child's information (legal name), Date, District, Program Site and SCOPE Account #
  - Section #1: Write in the specific allergies as the condition
  - Section #2: Child's name, Parent/Guardian name, Parent/Guardian signature and date
  - Do not leave any items blank

If any form is incorrect/incomplete, your child's start date may be delayed.

Complete and return the above referenced paperwork to: SCOPE.healthcare@scopeonline.us

Your child will not be able to start SCOPE until you have been contacted by a SCOPE Administrator to discuss and review your submitted paperwork.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

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

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ 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.

SCHOOL DISTRICT: SITE: 6/20
DIAGNOSIS: ALLERGY TO:
SYMPTOM AND TREATMENT OPTIONS:
********IF SEVERE ALLERGY SYPTOMS (ANAPHYLAXIS) ARE PRESENT ADMINISTER EPINEPHRINE AUTO INJECTOR IMMEDIATELY CALL 911 THEN CALL PARENT.**********
1) MILD ALLERGY SYMPTOMS MAY INCLUDE: ITCHY RED SKIN,RUNNY NOSE, ITCHY MOUTH THROAT, MILD HIVES.
ADMINISTER DIPHENHYDRAMINE AS ORDERED, IF AT THE PROGRAM, MONITOR CHILD CLOSELY TO SEE IF CONDITION IMPROVES.
2) SEVERE ALLERGY SYMPTOMS (ANAPHYLAXIS) MAY INCLUDE:SEVERE HIVES, SWELLING LIPS/FACE TROUBLE BREATHING.
ADMINISTER EPINEPHRINE AUTO INJECTOR AS ORDERED, IF AT THE PROGRAM, CALL 911 IMMEDIATELY,THEN PARENT.
3) IF THERE ARE NO MEDICATIONS AT PROGRAM (SCOPE FORM A),OR IF SYMPTOMS WORSEN; CALL 911 IMMEDIATELY,THEN CALL PARENT.
ALWAYS REMAIN WITH CHILD /ENCOURAGE CHILD TO TAKE SLOW DEEP BREATHS/REMAIN CALM
If the instructions on this form differ from the Medication Consent Form instructions, please follow the Health Care Providers instructions on the Medication Consent Form******

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)
	CPR,First Aid, Medication Administration Training (MAT)
	CPR,First Aid, Medication Administration Training (MAT)

NEW YORK STATE
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INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver 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 is trained in CPR& First Aid, some staff are trained to give medications (MAT). Additional staff training can be provided by SCOPE's Health Care Consultant if needed.
LIST ANY RESTRICTIONS OR LIMITATIONS WHILE AT SCOPE:

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: **X**		

Signature of Parent:

X	Date:

SCOPE FORM A

Child's Name: _____

Date: _____ **SCOPE Account#: _____**

School District: _____ **Program Site: _____**

SECTION #1:

You have indicated on the SCOPE Child Care on-line registration application that your child has the following physical, developmental, behavioral or emotional condition(s) expected to last 12 months or more which requires health and related services of a type or amount beyond that required by children generally, please list all condition(s) that apply:

_____

_____

SECTION # 2:

If your child does not require medication at SCOPE, complete and sign below and forward to SCOPE with a completed Individual Health Care Plan as soon as possible. (Your child cannot start SCOPE until this form and the Individual Health Care Plan has been received.)

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

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

If your child will require medication at SCOPE, DO NOT complete this form. The Individual Health Care Plan and Medication Consent Form(s) (one form per medication) must be completed and returned to SCOPE with the medication(s) before your child can attend the SCOPE program.

PLEASE EMAIL THIS COMPELED FORM AND INDIVIDUAL HEALTH CARE PLAN TO: scope.healthcare@scopeonline.us

THANK YOU FOR YOU PROMPT ATTENTION

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SCOPE STAFF ONLY: DESTROY THIS FORM UPON RECEIVING MEDICATION AND MEDICATION CONSENT FORM(S) FOR THE CONDITION(S) LISTED ABOVE.** **JUNE-2020