

**INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PLAN AND MEDICATION  
CONSENT FORM FOR CHILDREN WITH ALLERGIES**

***You indicated on your child's registration that your child has an allergy, and you will be providing SCOPE with medications.***

Per OCFS regulations, the attached "**Allergy To**" Individual Health Care Plan and Medication Consent Form(s) must be completed as follows (forms below):

- **Complete on page 1 of the Individual Health Care Plan**
  - Child's information, legal name, date of birth
  - Health 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.\***

***If SCOPE will administer medications***, per OCFS regulations, you must complete the **Medication Consent Form** as follows:

- **Items # 1-18 on page 1 must be completed by your child's physician**, along with # 33-35 on the back of this form if #12 and/or # 13 is checked "yes"
  - Every item must be complete, we cannot accept forms with missing information
- **Items # 19-23 on page 2 must be completed by the parent/guardian**
  - Every item must be completed we cannot accept forms with missing information
- **Items # 24-30 on page 2** will be completed by the program staff once they have received completed forms with matching medications

**\*Please do not combine multiple medications on the Medication Consent Form.\***

**INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PLAN AND MEDICATION CONSENT FORM FOR CHILDREN WITH ALLERGIES (CONTINUED)**

**PLEASE NOTE:**

1. Bring medications to be administered at the SCOPE program in their original package with attached pharmacy label, along with the corresponding completed Medication Consent Form(s) for the site director to review. Pharmacy label instructions must match the instructions on the Medication Consent Form. Over the counter medication must be labeled with the child's first and last name.
2. Medication Consent Forms and Medication Labels must accompany one another **and** match. If the Medication Consent Forms states "Epi Pen" and the medication label reads "Epinephrine", they do not match.
3. Please check the medication strength (children's strength vs. regular strength) on the form before making the medication purchase to ensure that it matches. **"Children's" must be indicated on the Medication Consent Form if the medication is children's strength. For example, Children's Benadryl the word "Children's" must be included on the Medication Consent Form if the word "Children's" is listed on the package or label.**
4. If possible, please ensure that the expiration date of the medication coincides with the end of the school year (June).
5. You must provide the program with the appropriate administration measurement tool for the medication. Please check the dosing information on the Medication Consent Form against the measuring tool included in the package to ensure that the tool measures what the medical provider ordered. For example if the medical provider indicated milliliters, ounces or teaspoons on the Medication Consent Form, you must provide the corresponding measurement tool to administer milliliters, ounces or teaspoons as indicated.
6. Sample medications are medications that are not dispensed by a pharmacy and supplied by the child's medical health care provider can be accepted with appropriate labeling. The label must include: child's first and last name, medication name, how often to give the medication, medication dose, date to stop giving the medication (discontinue date) or number of days to give the medication if applicable, and the health care prescriber's name who prescribed the medication. The medical health care provider can label the samples with the required information. They can be accepted with appropriate labeling.

**If any form or medication is incorrect/incomplete, SCOPE cannot accept the medication and *your child's start date may be delayed.***

Complete and return the above referenced paperwork to: [SCOPE.healthcare@scopeonline.us](mailto: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:	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> 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)

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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: <b>X</b>		

**Signature of Parent:**

<b>X</b>	Date:
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**MEDICATION CONSENT FORM**  
**CHILD DAY CARE PROGRAMS**

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

**LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).**

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication ( <i>including strength</i> ):	5. Amount/Dosage to be Given:	6. Route of Administration:
7A. Frequency to be administered: _____		
<b>OR</b>		
7B. Identify the symptoms that will necessitate administration of medication: ( <i>signs and symptoms must be observable and, when possible, measurable parameters</i> ): _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects ( <i>parent must supply</i> )		
<b>AND/OR</b>		
8B: Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below		
<input type="checkbox"/> Other ( <i>describe</i> ): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions ( <i>parent must supply</i> )		
<b>AND/OR</b>		
10B. Additional special instructions: ( <i>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 situation's when medication should not be administered.</i> ) _____		
11. Reason for medication ( <i>unless confidential by law</i> ): _____		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes   If you checked yes, complete (#33 and #35) 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? <input type="checkbox"/> No <input type="checkbox"/> Yes   If you checked yes, complete (#34 -#35) on the back of this form.		
14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /	
16. Licensed Authorized Prescriber's Name (please print):		17. Licensed Authorized Prescriber's Telephone Number:
18. Licensed Authorized Prescriber's Signature: <b>X</b>		

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**MEDICATION CONSENT FORM**  
CHILD DAY CARE PROGRAMS

**PARENT 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 licensed authorized prescriber write 12pm?)*  Yes  N/A  No

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

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name)*:

21. Parent's Name *(please print)*:

22. Date Authorized:

/ /

23. Parent's Signature:

**X**

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

24. Program Name:

25. Facility ID Number:

26. Program 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. Staff's Name *(please print)*:

29. Date Received from Parent:

/ /

30. Staff 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, 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 Signature:

**X**

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

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

34. 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 you are ordering the change in the administration of the prescription to take place.

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.

35. Licensed Authorized Prescriber's Signature:

**X**