

**INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HEALTH CARE PLAN FOR CHILDREN WITH SPECIAL NEEDS, NO MEDICATION AND A STUDENT PROFILE**

You indicated on your child's registration that your child has a special needs, and you are not providing SCOPE with any medications.

Per OCFS regulations, you must complete the attached **Individual Health Care Plan, Form A, and Student Profile Form**. Please note that one Individual Health Care Plan is required for each health care need indicated. If your child has asthma or allergies, please refer to the pre-filled Individual Health Care Plans. Complete these forms 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)
  - "Diagnosis" Section: indicate the diagnosis, or health care need if there is no diagnosis. One form is needed for each diagnosis - do not combine diagnoses onto one Plan.
  - "Symptoms" Section: indicate what staff should be aware of pertaining to this diagnosis/health care need, including behavior, learning delays, speech therapy, etc.
  - "Other Symptoms" Section (if none, write none; do not leave this section blank)
  - "Treatment" Section: Explain specifically how it pertains to your child in the program. You can list strategies our staff will use within the program to assist your child.
  - No section can be left blank. If there are no symptoms or treatments write "none"
- **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)
  - 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 condition with your child's diagnosis or health care need
  - Section #2: Child's name, Parent/Guardian name, Parent/Guardian signature and date
  - Do not leave any items blank
- To complete the **Student Profile Form**
  - Please provide as much specific information as you can so that we can assist your child with their special needs and provide a safe environment for your child
  - 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](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, and a 1:1 Aide has been secured for your child (if deemed necessary).***

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:		
SYMPTOMS:		
OTHER:		
TREATMENTS:		

**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)
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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 or parent if needed.
<b>LIST ANY RESTRICTIONS OR LIMITATIONS WHILE AT SCOPE:</b>

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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# 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: \_\_\_\_\_

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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](mailto: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*

## SCOPE STUDENT PROFILE/RELEASE FORM

Child's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Day time Phone #: \_\_\_\_\_  
District: \_\_\_\_\_ School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
SCOPE Site: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

The SCOPE registration application you completed for your child indicated areas of special needs. Please assist SCOPE in understanding your child's specific needs at SCOPE by completing this form and returning it to: SCOPE, 100 Lawrence Avenue, Smithtown, NY 11787 Attention: \_\_\_\_\_ or fax to (631)360-0356. If you are requesting a 1:1 aide, SCOPE will need to secure an additional staff member. You will be contacted to discuss how SCOPE can serve your child's individual needs. **Please use the reverse side or additional page if needed.**

1. Has your child attended a child care program? \_\_\_\_\_ If "Yes" where: \_\_\_\_\_  
Did your child have a 1:1 Aide in that program? \_\_\_\_\_
2. Does your child currently have a one-to-one Aide during the day? \_\_\_\_\_
3. Has your child been evaluated for learning and/or adjustment difficulties? YES \_\_\_ NO \_\_\_  
If yes, please share information: \_\_\_\_\_
4. Please describe your child's classroom setting including staffing or other modifications put in place: \_\_\_\_\_
5. Do you feel your child requires more direct supervision than the SCOPE 1:10 staff to student ratio? \_\_\_\_\_
6. Is your child's overall functioning within age/grade level expectations? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
7. Is your child able to socialize successfully with peers and adults? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
8. Does your child have difficulty working cooperatively with others? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
9. Does your child tend to do better in a quiet environment with minimum stimulation? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
10. Does your child adapt to routines easily? YES \_\_\_ NO \_\_\_
11. Would your child leave house/building without permission? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
12. Can your child communicate his/her wants and needs effectively? YES \_\_\_ NO \_\_\_  
Comments: \_\_\_\_\_
13. Please share any effective behavior management techniques: \_\_\_\_\_
14. Please list any sensory issues related to light, sound, smell, space etc. if applicable: \_\_\_\_\_
15. Is your child currently taking any medication? YES \_\_\_ NO \_\_\_  
If YES, please list: \_\_\_\_\_
16. Does your child require bathroom assistance? YES \_\_\_ NO \_\_\_
17. Is your child fully toilet trained? YES \_\_\_ NO \_\_\_
18. What activities does your child enjoy? \_\_\_\_\_
19. Please provide any additional information that would help your child succeed at SCOPE: \_\_\_\_\_
20. When are you available to speak and/or meet? \_\_\_\_\_

**I authorize SCOPE to obtain information from school personnel who are working with my child. I understand this information will be used for professional purposes only.**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Form 25**