

INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH ALLERGIES

MEDICATION TO BE PROVIDED

You indicated on your child's registration that your child has an allergy, and you will be providing SCOPE with medications. Per OCFS NYS license regulations, you must complete the attached Individual Health Care Plan, Medication Consent Form and the Individual Allergy and Anaphylaxis Emergency Form below:

The Individual Health Care Plan must be completed as follows:

- 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: List restrictions or 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 are 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

Note: Please do not combine multiple diagnoses onto one Individual Health Care Plan.

Medication Consent Form (complete a separate form for each medication to be administered):

- Items 1-18 on page 1 must be **completed by your child's health care provider**, along with numbers 33-35 on page 2 if #12 and/or #13 is checked "yes"
Note: Every item must be complete (forms with missing information will not be accepted)
- Items 19-23 on page 2 must be **completed by the parent/guardian**
Note: Every item must be complete (forms with missing information will not be accepted)
- Items 24-30 will be completed by the program staff once they have received completed forms with matching medications

Note: Please do not combine multiple medication on the Medication Consent Form.

The Individual Allergy and Anaphylaxis Emergency Plan must be completed as follows:

- **Page 1-** Parent/Guardian and child's health care provider complete entire page. Any items that are not applicable should be crossed out and initialed by the health care provider. Do not leave any items blank.
- **Page 2-** Parent/Guardian and child's health care provider complete DATE OF PLAN, MEDICATION/DOSES and MAT/EMAT CERTIFIED PROGRAM ONLY SECTION to match Medication Consent Forms. The health care provider should cross out and initial any items that are not applicable (for example, if child only has antihistamine and not epinephrine).
- **Page 3-** Parent/Guardian and child's health care provider complete and sign. If child only has epinephrine OR antihistamine, child's health care provider must state that in the STRATEGIES TO REDUCE RISK section.

ADDITIONAL INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH ALLERGIES WITH MEDICATION

1. Bring medication(s) 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.
2. Medication consent Forms and medication labels must accompany one another and match. If the Medication Consent Form states "Epi-pen" and the medication label reads "Epinephrine, they do not match.
3. Check the medication strength (children's strength vs. regular strength) on the form before purchasing the medication to be certain it matches. "Children's" must be indicated on the Medication Consent Form if the medication package or label states it is children's strength.
4. If possible, please ensure that the expiration date of the medication coincides with the end of the school year (June).
5. The appropriate administration measurement tool must be provided with the medication. Check the dosing information on the Medication Consent Form against the measuring tool included in the package to ensure 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 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 dates to give the medication, of applicable, and the name of the health care provider who prescribed the medication.

If any forms are incorrect/incomplete, your child's start date may be delayed!

Complete and return the above referenced paperwork to: SCOPE.health.care@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:	8/22
DIAGNOSIS: ALLERGY TO:		
SYMPTOM AND TREATMENT OPTIONS:		
*****IF SEVERE ALLERGY SYMPTOMS (ANAPHYLAXIS) ARE PRESENT ADMINISTER EPINEPHRINE AUTO INJECTOR IMMEDIATELY IF ORDERED AND AT PROGRAM ~CALL 911 THEN CALL PARENT.*****		
1) MILD ALLERGY SYMPTOMS MAY INCLUDE: ITCHY RED SKIN, RUNNY NOSE, ITCHY MOUTH THROAT, MILD HIVES.		
ADMINISTER DIPHENHYDRAMINE IF ORDERED, AND AT 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 IF ORDERED, AND AT 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**		
****OCFS Form 6029 Must be signed by Medical Provider and placed in the MAT Binder****		
If anaphylaxis is identified and /or an Epinephrine Auto Injector has been administered, OCFS must be notified immediately by using Form 4436 or an approved equivalent.		

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, and parent if needed.
MAT trained staff and program staff will be instructed by the parent, and or Health Care Consultant in the administration of Emergency Medications, (Epinephrine Auto Injector) when Emergency Medications are accepted at the program.
LIST ANY RESTRICTIOS 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:
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NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
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 (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: <input type="checkbox"/> 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:					
<input type="checkbox"/> Contact parent		<input type="checkbox"/> Contact health care provider at phone number provided below			
<input type="checkbox"/> Other (describe): _____					
10A. Special Instructions: <input type="checkbox"/> 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 situation's when medication should not be administered.) _____					
11. Reason for 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 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: X					

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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

NEW YORK STATE
 OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: _____ Date of Plan: ____ / ____ / ____
 Date of Birth: ____ / ____ / ____ Current Weight: _____ lbs.
 Asthma: Yes (higher risk for reaction) No

My child is reactive to the following allergens:

Allergen	Type of Exposure (i.e., air/skin contact/ingestion, etc.)	Symptoms include but are not limited to: (check all that apply)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)

If my child was **LIKELY** exposed to an allergen, for ANY symptoms:
 give epinephrine immediately

If my child was **DEFINITELY** exposed to an allergen, even if no symptoms are present:
 give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 Immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored: Inaccessible to children, and will go where child goes in a fanny pack, backpack, or in a medication container inside a locked cabinet.

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area. Explain here: Inaccessible to children, and will go where child goes in a fanny pack, backpack, or in a medication container inside a locked cabinet

