OCFS-LDSS-7006 (5/2014) FRONT

### 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 of 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 w	ifh the child's n	arent and child's health care provider, the program has developed t	
following health care plan	to meet the ind	ividual needs of:	ne
Child Name:		Child date of birth:	
Name of the child's health care	provider:		
		Physician	
!		Physician Assistant	
		☐ Nurse Practitioner	
Describe the special healtl	h care needs of	this child and the plan of care as identified by the parent and the characters are the characters and the characters are the ch	ild'e
		information completed on the medical statement at the time of enroll	ment or
The state of the s	roliment.		inche of
SCHOOL DISTRICT:		SITE:	8/22
DIAGNOSIS: ALLERGY	TO:		0/22
SYMPTOM AND TREAT	MENT OPTION	S:	
**************************************	RGY SVMPTO	MS (ANAPHYLAXIS) ARE PRESENT ADMINISTER EPINEPHRINE	
INJECTOR IMMEDIATEL	Y IF ORDERE	O AND AT PROGRAM ~CALL 911 THEN CALL PARENT.*********	AUTO
	CA OKOLIKLI	DAND AT PROGRAM ~CALL 911 THEN CALL PARENT.*********	
1) MII DALLEDGY CYNT	)		
MILD HIVES.	TOWS WAY IN	ICLUDE: ITCHY RED SKIN,RUNNY NOSE, ITCHY MOUTH THRO	AT,
CONDITION IMPROVES	DRAMINE IF (	DRDERED, AND AT PROGRAM, MONITOR CHILD CLOSELY TO	SEE IF
The state of the s			
TROUBLE BREATHING.	TWPTOMS (AN	APHYLAXIS) MAY INCLUDE:SEVERE HIVES, SWELLING LIPS/F,	ACE
IMMEDIATELY, THEN PA	UNE AUTO INJ	ECTOR IF ORDERED, AND AT PROGRAM. CALL 911	
	r⊑ixi.		
OALL SALE ARE NO ME	DICATIONS A	TPROGRAM (SCOPE FORM A), OR IF SYMPTOMS WORSEN;	
OF COLUMNIA	, I DEN CALL P.	ARFNI	
ALWAYS REMAIN WITH	CHILD /ENCOL	JRAGE CHILD TO TAKE SLOW DEEP BREATHS/REMAIN CALM	
		TO THE PROPERTY OF THE PROPERT	Ì
u			
***If the instructions on this	s form differ from	n the Medication Consent Form instructions, please follow the Heal	
Providers instructions on the	he-Medication (	Consent Form#######	in Care
****OCES Form 6029 Must	t he cianed by D	April 1 Dec. 11	
If anaphylavic is identified	t be signed by I	dedical Provider and placed in the MAT Binder*****	
immediately by using Farm	and /or an ⊟pin	ephrine Auto Injector has been administered, OCFS must be notifie	ed
THE RESERVE OF THE PARTY OF THE	TTOO OF ALL AU	proved equivalent	
lentify the caregiver(s) w	ho will provide	e care to this child with special health care needs:	
Caregiver's Nar	ne	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 same staff to-	
can be provided by SCOPE's Healt	hid, some starr are trained to give medi th Care Consultant,and parent if neede	ications, (MAT). Additional staff training d.
MAT trained staff and my	<b>.</b>	
administration of Emergency Medical	f will be instructed by the parent, and o	r Health Care Consultant in the
at the program	ations, (Epinephrine Auto Injector) who	r Health Care Consultant in the en Emergency Medications are accepted
:		
LIST ANY RESTRICTIOS OR LIMIT	ATIONS WHILE AT SCOPE:	
an are familiar with the child care road	ulations and have received any addition ent and medication in accordance with	child's health care provider. The caregivers ed in the specialized individual health care hal training needed and have demonstrated the plan identified.
riogram Name;	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
		Date:
Child care provider's signature: X		
ignature of Parent:		
<		Date:
•		

## SCOPE FORM A

Date:	SCOPE Account #:
School District:	Program Site:
SECTION #1: You have indicated on the SCOP the following physical, developm last 12 months or more which required by children general!	PE Child Care on-line registration application that your child hat nental, behavioral, emotional or other condition(s) expected to quires health and related services of a type or amount beyond by; please list all condition(s) that apply:
cannot start SCOPE until this form  My child,  during the SCOPE program.  Parent/Guardian Name:	dication at the SCOPE program, complete and sign below and ted Individual Health Care Plan soon as possible. (Your child m and the Individual Health Care Plan has been received.)  does not require the medication
Parent Signature: Date	
t your child <u>will require medication</u> The Individual Health Care Plan are	on while at SCOPE, DO NOT complete this form.  d Medication Consent Form(s) (one form per medication)  SCOPE with the medication(s) before your child can attend
LEASE EMAIL THIS COMPLE EALTH CARE PLAN TO: <u>SC</u> O	ETED FORM AND COMPLETED INDIVIDUAL  OPE.healthcare@scopeonline.us.
THANK YOU I	FOR YOUR PROMPT ATTENTION
COPE STAFF ONLY. DECEDANGER	IS FORM UPON RECEIVING MEDICATION AND PR THE CONDITION(S) LISTED ABOVE.

#### **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
- Add additional sheets if additional documentation or instruction is necessary.

Date of Birth: / Asthma: ☐ Yes (high My child is reactive to	the following alle	gens:	
my child was LIKELY ex  give epinephrine in  my child was DEFINITE!  give epinephrine im	posed to an allergen	of/ingestion; etc.)	Shortness of breath, wheezing, or coughing Pale or bluish skin, faintness, weak pulse, dizziness Tight or hoarse throat, trouble breathing or swallowing Significant swelling of the tongue or lips Many hives over the body, widespread redness Vomiting, diarrhea Behavioral changes and inconsolable crying Other (specify) Shortness of breath, wheezing, or coughing Pale or bluish skin, faintness, weak pulse, dizziness Tight or hoarse throat, trouble breathing or swallowing Significant swelling of the tongue or lips Many hives over the body, widespread redness Vomiting, diarrhea Behavioral changes and inconsolable crying Other (specify) Shortness of breath, wheezing, or coughing Pale or bluish skin, faintness, weak pulse, dizziness Tight or hoarse throat, trouble breathing or swallowing Significant swelling of the tongue or lips Many hives over the body, widespread redness Vomiting, diarrhea Behavioral changes and inconsolable crying Other (specify) Other (specify) Other (specify)

OCFS-6029 (01/2021)
Date of Plan: / /
<ul> <li>THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:</li> <li>Inject epinephrine immediately and note the time when the first dose is given.</li> <li>Call 911/local rescue squad (Advise 911 the child is in anaphylaxis and may need epinephrine when emergence responders arrive).</li> <li>Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up the person flat.</li> </ul>
<ul> <li>If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.</li> <li>Alert the child's parents/guardians and emergency contacts.</li> <li>After the needs of the child and all others in care have been met, immediately notify the office.</li> </ul>
MEDICATION/DOSES
<ul> <li>Epinephrine brand or generic:</li> <li>Epinephrine dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM</li> </ul>
ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS  When administering an epinephrine auto-injector follows to
mid-outer thigh. If a staff member is accidentally injected, they should seek medical aftertion at the property
<ul> <li>If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to</li> <li>Epinephrine can be injected through clothing if needed.</li> <li>Call 911 immediately after injection.</li> </ul>
and 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:

### 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 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

# 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.

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to mirrimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:	 				
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	 <del></del>				
				<u>.</u>	
EMERGENCY CONTROL SOME CONTROL SOME			·		
EMERGENCY CONTACTS CALL 911					
Ambulance: ( )					
Ambulance: ( )  Child's Health Care Provider:		10pe #: /			
Ambulance: ( )  Child's Health Care Provider:  Parent/Guardian:	Pi	none #: (	)	7	
Ambulance: ( )  Child's Health Care Provider:  Parent/Guardian:  CHILD'S EMERGENCY CONTACTS	Pi Pi	one#:(	)		
Ambulance: ( ) – Child's Health Care Provider: Parent/Guardian: HIED'S EMERGENCY CONTACTS	PI PI	ione #: (	<u>)</u> )		
Ambulance: ( ) – Child's Health Care Provider: Parent/Guardian: HIED'S EMERGENCY CONTACTS	Pr Pr Ph	one #: ( one#: (	)		
Ambulance: ( ) – Child's Health Care Provider: Parent/Guardian: CHILDIS EMERGENCY CONTACTS   ame/Relationship:	Pr Pr Ph	ione #: (	) )	-	
Ambulance: ( ) - Child's Health Care Provider: Parent/Guardian: CHILDIS EMERGENCY CONTACTS  Jame/Relationship: ame/Relationship: ame/Relationship:	Pi Pi Ph	one #: ( one#: (	)	-	
Ambulance: ( ) - Child's Health Care Provider: Parent/Guardian: CHILDIS EMERGENCY CONTACTS   ame/Relationship: ame/Relationship: ame/Relationship:	Pi Pi Ph	one#: ( one#: (	)	-	
Ambulance: ( ) Child's Health Care Provider: Parent/Guardian: PHILIPIS EMERGENCY GONTACTS  Jame/Relationship: ame/Relationship: ame/Relationship: arrent/Guardian Authorization Signature:	Ph Ph Ph	one#: ( one#: (	)	-	
EMERGENCY CONITACTS CALL 914  Ambulance: ( ) —  Child's Health Care Provider:  Parent/Guardian:  CHILD'S EMERGENCY CONITACTS  Jame/Relationship:  Jame/Relationship:	Ph Ph Ph Pho	one #: ( one#: ( one#: (	)	-	