

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)
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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 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, emotional or other 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 the SCOPE program, complete and sign below and forward to SCOPE with a completed Individual Health Care Plan 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 Signature: _____

Date _____

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If your child will require medication while 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 COMPLETED FORM AND COMPLETED INDIVIDUAL HEALTH CARE PLAN TO: SCOPE.healthcare@scopeonline.us.

THANK YOU FOR YOUR 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.***

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:

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:

