INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH ALLERGIES

*****NO MEDICATION*****

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

Per OCFS license regulations, you must complete the attached **"Allergy To" Individual Health Care Plan** as follows, a **Form A**, and an **Individual Allergy and Anaphylaxis Emergency Plan** (see below):

- Please indicate the following, found on **page 1** of the **Individual Health Care Plan**
  - Child information, legal name, date of birth
  - Heath care provider name and discipline (MD, PA, NP, etc.)
  - School district
  - Site (SCOPE program location)
  - Specific allergies
- Please indicate the following, found on **page 2** of the **Individual Health Care Plan**
  - In the ***"Most staff is trained in CPR and First Aid"*** section, please 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.
  - Answer both Yes/No questions.
  - Parent/guardian signature and date

  NOTE: Please do not combine multiple diagnoses onto one Individual Health Care Plan.
- Please indicate the following on the **Form A**
  - Child's information (legal name), date, district/site and SCOPE account #
  - Section #1: Write in the specific allergies as the condition
  - Section #2: Child's name, Parent/Guardian name, Parent/Guardian signature and date
  - Do not leave any items blank
- Please complete the following information on the **Individual Allergy and Anaphylaxis Emergency Plan**
  - Page 1- Parent/guardian and child's health care provider complete child name, date of plan, DOB, weight, asthma question, and allergen/exposure/symptoms. Do not leave any items blank.
  - Page 2 – date of plan at top of page
  - Page 3 - Parent/guardian and child's health care provider complete emergency contacts and sign

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

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.

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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:	☐ Physician ☐ Physician Assistant ☐ 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: PROGRAM: 4/23
DIAGNOSIS: ALLERGY TO:
SYMPTOM AND TREATMENT OPTIONS:
********IF SEVERE ALLERGY SYMPTOMS (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 IF AT PROGRAM CALL 911 IMMEDIATELY,THEN 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******
*** OFCS Form 6029 must be completed and signed by parent, program staff and medical provider*******

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/FA/AED Medication Administration Training (MAT)
	CPR/FA/AED 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 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:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

SCOPE FORM A

Child's Name: _____

Date: _____ **SCOPE Account#:** _____

School District: _____ **Program Site:** _____

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:

_____

_____

_____

NOTE: If your child <u>does not require medication at SCOPE</u>, 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: _____

If your child <u>will require medication at SCOPE, DO NOT complete this form</u>. 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) <u>before</u> your child can attend the SCOPE program.

PLEASE EMAIL THIS COMPELED FORM AND INDIVIDUAL HEALTH CARE PLAN TO: scope.healthcare@scopeonline.us

THANK YOU FOR YOU PROMPT ATTENTION

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<u>SCOPE STAFF ONLY</u>: DESTROY THIS FORM UPON RECEIVING MEDICATION AND MEDICATION CONSENT FORM(S) FOR THE CONDITION(S) LISTED ABOVE.

2023

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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*)
		☐ 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)

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:

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:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

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

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /