**INSTRUCTIONS FOR COMPLETING INDIVIDUAL HEALTH CARE PLAN FOR**

**FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS AND NO MEDICATIONS**

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

Per OCFS license regulations, you must complete the attached **Individual Health Care Plan** and a **Form A** as follows (see forms 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 Health Care Need
  - "Diagnosis" Section: Indicate the diagnosis, or health care need if there is not diagnosis. One form is needed for each diagnosis. Do not combine diagnoses onto one Individual Health Care Plan Form.
  - "Symptoms" Section: Indicate what staff should be aware of pertaining to this diagnosis/health care need.
  - "Other Symptoms" Section (if not, 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 SCOPE staff can use within the program to assist your child.
  - No section can be left blank. If there are no symptoms or treatments write "none".

- 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
  - Answer both Yes/No questions
  - Parent/guardian signature and date

- Please indicate the following on **Form A**
  - Child's information (legal name), Date, District, Program Site and SCOPE Account #
  - Section #1: Write 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

**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.***

4/23

# 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 may need time 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?*
   YES ___ NO____ ***If after working with your child it is determined your child requires closer supervision, it may be necessary to withdraw your child from the program until a 1:1 can be secured.**
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 district personnel for the purpose of assisting SCOPE in working with my child. I understand this information will be used for professional purposes only.**

**Parent Name (Print):** _____ **Signature:** _____ **Date:** _____

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: | ☐ Physician<br>☐ Physician Assistant<br>☐ 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: | | |
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**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) |

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# 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.

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:<br>**X** | | |

**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 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**

**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.***

*2023*