INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHIDREN WITH ASTHMA

MEDICATION TO BE PROVIDED

You indicated on your child's registration that your child has asthma, and you will be providing SCOPE with medications.

Per OCFS license regulations, the attached **"Asthma" Individual Health Care Plan** and **Medication Consent Form(s)** must be completed as follows (forms below):

- Complete on page 1 of the **Individual Health Care Plan**
  - Child's information, legal name, date of birth
  - Heath care provider name and discipline (MD, PA, NP, etc.)
  - School district
  - Site (SCOPE program location)
  - Specific triggers of asthma

- Complete 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

NOTE: Please do not combine multiple diagnoses on the 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)
- Numbers 19-23 on page 2 is **to be completed by the parent/guardian**
  Note: Every item must be complete (forms with missing information will not be accepted)
- Numbers 24-30 are completed by the program staff once they have received completed forms with matching medications

NOTE: Please do not combine multiple diagnoses on the Medication Consent Form.

- Bring medications in the original package with Rx label to the program with the forms for the site director to review
  *Please note, forms and medications must accompany one another **and** match. If your forms says "Epi Pen" and the medication is "Epinephrine", this does not match. Please also check the medication strength (children's vs. regular strength) on the form before making the medication purchase to ensure that it matches.

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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: ASTHMA

SYMPTOMS:RAPID BREATHING, WHEEZING, OPEN MOUTH BREATHING, FLARING NOSTRILS, GRUNTING REDDENED, PALE OR SWOLLEN FACE, PERSISTENT COUGH, COMPLAINING OF CHEST PAIN OR TIGHTNESS, RESTLESSNESS AGITATION DIFFICULTY TALKING,EATING DRINKING OR PLAYING FATIGUE GRAY OR BLUE NAILBEDS/LIPS

TRIGGERS:

TREATMENT AT THE FIRST SIGN OF SYMPTOMS:

1)IF NO MEDICATIONS CALL 911 IMMEDIATELY, THEN CALL PARENT

2) IF MEDICATIONS ARE AT THE PROGRAM, ADMINISTER MEDICATIONS

IF NO IMPROVEMENTS OR CONDITION WORSENS AFTER ADMINISTERING MEDICATION(S), CALL 911 IMMEDIATELY, THEN NOTIFY PARENT

3)ALWAYS REMAIN WITH THE CHILD/ ENCOURAGE CHILD TO TAKE DEEP BREATHS/ REMAIN CALM

CHILD MAY BE ACCOMPANIED BY STAFF TO HOSPITAL IF NO PARENT/GUARDIAN PRESENT

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 Medicaton Administration Training (MAT)
	CPR/FA AED Medicaton Administration Training (MAT)

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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 Parent or Health Care Consultant, if needed.

MAT trained staff and program staff will be instructed by parent and or Health Care Consultant in the administration of Emergency Medications. (Epinepehrine Auto Injector) when Emergency Medications are accepted at the program.

LIST ANY RESTRICTIONS WHILE AT SCOPE PROGRAM:

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: / /

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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: ☐ 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:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe)*: ______

10A. Special instructions: ☐ 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?

☐ No ☐ 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?

☐ No ☐ 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