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, or list 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)

- If spacer is ordered by Health Care Provider it must be stated in #6 on Medication Consent Form
- 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.

- Submit phots of Rx label and expiration via email with forms

INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH ASTHMA

MEDICATION TO BE PROVIDED (CONTINUED)

PLEASE NOTE:

1. Bring medications to be administered at the SCOPE program in their original package with attached pharmacy label, along with the corresponding completed Medication Consent Form(s) for the Site Director to review. Pharmacy label instructions must match the instructions on the Medication Consent Form. Over the counter medication must be labeled with the child's first and last name.

2. Medication Consent Forms and Medication Labels must accompany one another **and** match. If "Ventolin" is listed on the Medication Consent Form and the medication is "Albuterol", they do not match. If your child requires a Spacer or Opti Chamber or Aero Chamber, this device must be listed on both the pharmacy label and the Medication Consent Form.

3. If possible, please ensure that the expiration date of the medication coincides with the end of the school year (June).

4. You must provide the program with the appropriate administration measurement tool for the medication. Please check the dosing information on the Medication Consent Form against the measuring tool included in the package to ensure that the tool measures what the medical provider ordered. For example, if the medical provider indicated milliliters, ounces or teaspoons on the Medication Consent Form, you must provide the corresponding measurement tool to administer milliliters, ounces or teaspoons as indicated.

5. Sample medications are medications that are not dispensed by a pharmacy and supplied by the child's medical health care provider can be accepted with appropriate labeling. The label must include: child's first and last name, medication name, how often to give the medication, medication dose, date to stop giving the medication (discontinue date) or number of days to give the medication, if applicable, and the health care prescriber's name who prescribed the medication. The medical health care provider can label the samples with the required information. They can be accepted with appropriate labeling.

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.

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 ☐ 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)

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 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: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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