INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH SPECIAL HEALTH NEEDS
**** NO MEDICATION****

You indicated on your child's registration that your child has a special health need (i.e., glasses, sprain/fracture, ADHD) and you are not providing SCOPE with any medications. You are required to complete an **Individual Health Care Plan and Form A** to be in compliance with OCFS regulations. If your child has asthma or allergies, please refer to the pre-filled Individual Health Care Plans.

The Individual Health Care Plan must be completed as follows:

- Front:
  - Child Information, Legal Name, Date of Birth
  - Heath Care Provider Name and Discipline (MD, PA, NP, DO)
  - School District
  - Site (SCOPE program location)
  - "Diagnosis" Section: Indicate the diagnosis, or special need if there is no diagnosis. One form is needed for each diagnosis/need. ***Please do not combine multiple diagnoses onto one Individual Health Care Plan.***
  - Please do not state "IEP" or "504 Plan". Please indicate the reason.
  - "Symptoms" Section: Indicate what staff should be aware of pertaining to their diagnosis/need and list items that staff should be aware of, including behavioral issues, learning delays, speech, OT, PT, etc.
  - "Other" Section: If none, write "None." Do not leave this section blank
  - "Treatment" Section: List strategies (behavior plans, redirection, etc.) staff can use within the program to assist your child.
  - If there are no symptoms/treatments, please write "None." Do not leave a section blank.
- Reverse:
  - List any restrictions or write "None" if there are no restrictions
  - Check Yes/No if this Health Care Plan meets the needs of your child
  - Check Yes/No if you give consent to share information regarding your child's needs
  - Parent/Guardian Signature and Date

NOTE: Please do not combine multiple diagnoses onto one Individual Health Care Plan.

Form A must be completed as follows:

- Child's Information (Legal Name), Date, District/Site and SCOPE account #
- Section #1: Write in the Diagnosis/Special Health Care Need as the condition
- Section #2: Child's Name, Parent/Guardian Name, Parent/Guardian Signature and Date
- Do not leave any items blank

Your child will not be able to start SCOPE until you have been contacted by a SCOPE Administrator to discuss, review and approve your submitted paperwork, and a 1:1 Aide has been secured for your child (if deemed necessary).

If any form is incorrect or incomplete, your child's start date will be delayed, and your child will not be able to start on your first scheduled day.

INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH SPECIAL HEALTH NEEDS

****NO MEDICATION****

Complete and return the above referenced paperwork on Page 1 to your assigned District Field Manager below:

Suffolk School Districts

Babylon -Tete Quarcoo-tquarcoo@scopeonline.us
Bayport/Blue Point- Grace Fischer: gfischer@scopeonline.us
Brentwood – Tete Quarcoo: tquarcoo@scopeonline.us
Center Moriches – Tete Quarcoo: tquarcoo@scopeonline.us
Commack – Shannon Costarelli: scostarelli@scopeonline.us
Connetquot –Tete Quarcoo: tquarcoo@scopeonline.us
Copiague – Ewa Krzal: ekrzal@scopeonline.us
Deer Park – Cynthia Ortiz: cortiz@scopeonline.us
East Moriches – Tete Quarcoo: tquarcoo@scopeonline.us
Hampton Bays – Tete Quarcoo: tquarcoo@scopeonline.us
Harborfields – Shannon Costarelli: scostarelli@scopeonline.us
Hauppauge – Cynthia Ortiz: cortiz@scopeonline.us
Huntington – Shannon Costarelli: scostarelli@scopeonline.us
Lindenhurst – Colleen Conrad: cconrad@scopeonline.us
Mattituck – Tete Quarcoo: tquarcoo@scopeonline.us
Middle Country – Grace Fischer: gfischer@scopeonline.us
Miller Place – Melissa Kromer: mkromer@scopeonline.us
Northport - Shannon Costarelli: scostarelli@scopeonline.us
Riverhead – Tete Quarcoo: tquarcoo@scopeonline.us
Sachem – Melissa Kromer: mkromer@scopeonline.us
Sayville - Grace Fischer: gfischer@scopeonline.us
Southold-Tete Quarcoo: tquarcoo@scopeonline.us
Westhampton-Tete Quarcoo: tquarcoo@scopeonline.us

Nassau School Districts

Carle Place – Jay Awasthi : jawasthi@scopeonline.us
Bethpage - Ewa Krzal: ekrzal@scopeonline.us
East Meadow Day Care - Ewa Krzal: ekrzal@scopeonline.us
East Meadow - Ewa Krzal: ekrzal@scopeonline.us
East Rockaway -Nicolette Baxter: nbaxter@scopeonline.us
East Williston – Jay Awasthi: jawasthi@scopeonline.us
Elmont - Nicolette Baxter: nbaxter@scopeonline.us
Floral Park/Bellerose - Cherie Sexton: csexton@scopeonline.us
Garden City - Cynthia Ortiz: cortiz@scopeonline.us
Great Neck - Nicolette Baxter: nbaxter@scopeonline.us
Hewlett-Woodmere - Nicolette Baxter: nbaxter@scopeonline.us
Hicksville – Colleen Conrad: cconrad@scopeonline.us
Island Trees - Ewa Krzal: ekrzal@scopeonline.us
Jericho - Colleen Conrad: cconrad@scopeonline.us
Locust Valley - Jay Awasthi: jawasthi@scopeonline.us
Mineola - Jay Awasthi: jawasthi@scopeonline.us
Roslyn - Jay Awasthi: jawasthi@scopeonline.us
Seaford – Colleen Conrad: cconrad@scopeonline.us
Syosset – Cynthia Ortiz: cortiz@scopeonline.us
Uniondale - Cherie Sexton: csexton@scopeonline.us
Valley Stream 24- Cherie Sexton: csexton@scopeonline.us
Valley Stream 30- Cherie Sexton: csexton@scopeonline.us
Wantagh – Colleen Conrad: cconrad@scopeonline.us
West Hempstead- Cherie Sexton: csexton@scopeonline.us

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:		
SYMPTOMS:		
OTHER:		
TREATMENT:		

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)

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 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 RESTRICTIOS 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:** _____

SECTION #1:
You have indicated on the SCOPE Child Care on-line registration application that your child has the following chronic 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 you elect not to provide medication at the SCOPE program, complete and sign below and forward to SCOPE with a completed Individual Health Care Plan (and Individual Allergy and Anaphylaxis Emergency Plan **only** if your child has an allergy). Your child **cannot** start SCOPE until all required forms are received.

I will not be providing SCOPE with medication for my child, _____.

Note: In accordance with Elijah's Law, SCOPE staff will administer a non-child specific auto injector to any child without medication at SCOPE who experiences anaphylaxis.

Parent/Guardian Name: _____

Parent Signature: _____ **Date:**_____

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PLEASE EMAIL ALL COMPLETED FORMS TO YOUR DISTRICT FIELD MANAGER. CONTACT INFORMATION IS LOCATED ON THE INSTRUCTIONS PAGE.

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.

4/25/25