INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH SPECIAL HEALTH NEEDS

****MEDICATION TO BE PROVIDED****

You indicated on your child's registration that your child has a special health need (i.e., diabetes, seizure disorder, etc.) and you are providing SCOPE with medication. You must complete an **Individual Health Care Plan, Medication Consent Form, and Student Profile Form** 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. 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 (behavioral 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.

Medication Consent Form must be completed as follows: (complete a separate form for each medication to be administered):

- Items 1-18 must be **completed by your child's Health Care Provider**. If items 12 and/or 13 are checked yes, then items 33-35 must also be completed
- Items 19-23 are **to be completed by the Parent/Guardian**
- Items 24-30 are completed by the program staff only
- **Medication** must be in the **original container** with the **original pharmacy label**. 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. Please check the expiration date. If any form or medication is incorrect/incomplete, SCOPE cannot accept medication and *your child's start date will be delayed*.

Please note that forms and medications must accompany one another **and match. If the Medication Consent Form only has the brand name, we cannot accept the generic medication at the program.

**Please check the medication strength on the form to ensure it matches the Medication Consent Form

**Provide correct medication tool to measure the dose specified on the Medication Consent Form

Note: Every item must be complete (forms with missing information will not be accepted)

INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

****MEDICATION TO BE PROVIDED****

The Student Profile Form must be completed as follows:

- Please be as specific with your information as possible to best help our staff understand and assist your child and provide a safe environment at the SCOPE program.
- Answer all questions. Do not leave any items blank

Complete and return the above referenced paperwork, along with a picture of the medication, expiration date, and Rx label to your District Field Manager:

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

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 their first scheduled day.

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 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: / /

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

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.**