INSTRUCTIONS FOR COMPLETING REQUIRED FORMS FOR CHILDREN WITH ALLERGIES

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

You indicated on your child's registration that your child has an allergy, and you will be providing SCOPE with medication. You must complete a pre-filled **"Allergy To" Individual Health Care Plan**, **Medication Consent Form(s),** and the **Individual Allergy and Anaphylaxis Emergency Form** to be in compliance with OCFS regulations.

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)
  - Specific allergies

- Reverse:
  - 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
    For food allergies only, you must state specifically which SCOPE snacks are approved for your child, or if all SCOPE snacks are approved, or if no SCOPE snacks are approved. All SCOPE snacks are peanut and tree nut free. Contact SCOPE if you need additional information about our snacks.
  - 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

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

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

- 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, 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 also check the medication strength 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 ALLERGIES

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

Individual Allergy and Anaphylaxis Emergency Plan must be completed as follows:

- Page 1- Parent/Guardian and child's Health Care Provider complete child name, date of plan, DOB, weight, asthma question, and allergen/exposure/symptoms. Do not leave any items blank. The check boxes at the bottom of the page must be checked or include alternate instructions.
- Page 2 - Parent/Guardian and child's Health Care Provider complete "Date of Plan", "MEDICATION/DOSES" and "MAT/EMAT CERTIFIED PROGRAM ONLY" sections to match Medication Consent Forms. Cross out any items that are not applicable and initial (for example, if child only has antihistamine and not epinephrine).
- Page 3 – Complete the "Strategies to Reduce Risk" section. If child only has epinephrine OR antihistamine, child's Health Care Provider must state that in this section. Parent/Guardian and child's Health Care Provider sign, date and complete Emergency Contact Sections.

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, and it is approved.

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.

Complete and return the above referenced paperwork on Page 1, along with a picture of the medication, expiration date, and Rx label to your assigned District Field Manager below:

Suffolk School Districts

Babylon – Colleen Conrad: cconrad@scopeonline.us
Bayport/Blue Point – Grace Fischer: gfischer@scopeonline.us
Center Moriches – Tete Quarcoo: tquarcoo@scopeonline.us
Commack – Shannon Costarelli: scostarelli@scopeonline.us
Connetquot – Tete Quarcoo: tquarcoo@scopeonline.us
Deer Park – Cynthia Ortiz: cortiz@scopeonline.us
East Moriches – Tete Quarcoo: tquarcoo@scopeonline.us
Eastport-South Manor – Tete Quarcoo: tquarcoo@scopeonline.us
Hampton Bays – Tete Quarcoo: tquarcoo@scopeonline.us
Harborfields – Shannon Costarelli: scostarelli@scopeonline.us
Hauppauge – Tete Quarcoo: tquarcoo@scopeonline.us
Huntington – Shannon Costarelli: scostarelli@scopeonline.us
Lindenhurst – Colleen Conrad: cconrad@scopeonline.us
Longwood – Grace Fischer: gfischer@scopeonline.us
Middle Country – Grace Fischer: gfischer@scopeonline.us
Miller place – Tete Quarcoo: tquarcoo@scopeonline.us
Mattituck-Cutchogue – Tete Quarcoo: tquarcoo@scopeonline.us
Northport – Shannon Costarelli: scostarelli@scopeonline.us
Sachem – Melissa Kromer: mkromer@scopeonline.us
Sayville – Melissa Kromer: mkromer@scopeonline.us
Southold – Tete Quarcoo: tquarcoo@scopeonline.us
West Babylon – Colleen Conrad: cconrad@scopeonline.us
Westhampton Beach– Tete Quarcoo: tquarcoo@scopeonline.us

Nassau School Districts

Carle Place – Cherie Sexton: csexton@scopeonline.us
Bethpage – Jay Awasthi: jawasthi@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 – Jay Awasthi: jawasthi@scopeonline.us
Hewlett-Woodmere – Nicolette Baxter: nbaxter@scopeonline.us
Hicksville – Jay Awasthi: jawasthi@scopeonline.us
Island Trees – Jay Awasthi: jawasthi@scopeonline.us
Jericho – Cynthia Ortiz: cortiz@scopeonline.us
Locust Valley – Jay Awasthi: jawasthi@scopeonline.us
Lynbrook – Nicolette Baxter: nbaxter@scopeonline.us
Mineola – Cherie Sexton: csexton@scopeonline.us
North Bellmore – Ewa Krzal: ekrzal@scopeonline.us
Roslyn – Jay Awasthi: jawasthi@scopeonline.us
Seaford – Colleen Conrad: cconrad@scopeonline.us
Syosset – Cynthia Ortiz: cortiz@scopeonline.us
Uniondale – Nicolette Baxter: nbaxter@scopeonline.us
Valley Stream 24 – Cherie Sexton: csexton@scopeonline.us
Valley Stream 30 – Cherie Sexton: csexton@scopeonline.us
Wantagh – Colleen Conrad: cconrad@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: ALLERGY TO:
SYMPTOM AND TREATMENT OPTIONS:
********IF SEVERE ALLERGY SYMPTOMS (ANAPHYLAXIS) ARE PRESENT ADMINISTER EPINEPHRINE AUTO INJECTOR IMMEDIATELY CALL 911 THEN CALL PARENT **********
1) MILD ALLERGY SYMPTOMS MAY INCLUDE: ITCHY RED SKIN,RUNNY NOSE, ITCHY MOUTH THROAT, MILD HIVES.
ADMINISTER DIPHENHYDRAMINE AS ORDERED, IF AT THE PROGRAM, MONITOR CHILD CLOSELY TO SEE IF CONDITION IMPROVES.
2) SEVERE ALLERGY SYMPTOMS (ANAPHYLAXIS) MAY INCLUDE:SEVERE HIVES, SWELLING LIPS/FACE
TROUBLE BREATHING.
ADMINISTER EPINEPHRINE AUTO INJECTOR IF AT PROGRAM CALL 911 IMMEDIATELY,THEN PARENT.
ALWAYS REMAIN WITH CHILD.ENCOURAGE CHILD TO TAKE SLOW DEEP BREATHS/REMAIN CALM
If the instructions on this form differ from the Medication Consent Form instructions, please follow the Health Care Providers instructions on the Medication Consent Form******
*** OFCS Form 6029 must be completed and signed by parent, program staff and medical provider*******

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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	Type of Exposure: (*i.e., air/skin contact/ingestion, etc.*):	Symptoms include but are not limited to: (*check all that apply*)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here: _____

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /