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:

following health care plan to meet the indiv	idual needs of:
CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDE	R: Physician Physician Assistant Nurse Practitioner
	his child and the plan of care as identified by the parent and the child's formation completed on the medical statement at the time of enrollment or
Identify the caregiver(s) who will provid	e care to this child with special health care needs:
Caregiver's Name	Credentials or Professional License Information (if applicable)

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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.

who will provide this training.			
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identified to provide all treatr plan are familiar with the chik	lose collaboration with the child's parent and ments and administer medication to the child dicare regulations and have received any ad uch treatment and medication in accordance	ld listed in the specialized individual hea Iditional training needed and have demo	alth care
PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:	
CHILD CARE PROVIDER'S NAME	E (PLEASE PRINT);	DATE:	
CHILD CARE PROVIDER'S SIGN	IATURE:		
l agree this Individual Health	Care Plan meets the needs of my child.	Yes No No	コ
the strategies the program in	mation about my child's allergy with all prog nplements to keep my child from being exp I reminders that may result in the disclosure Yes	osed to known allergen(s). I acknowledge of my child's confidential allergy inform	ge these
Signature of Parent:			
х		DATE:	

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: /	1
Date of Birth: /	/ Current W	eight: Ibs.
Asthma: Yes (hig	her risk for reaction) 🔲 No	
My child is reactive t	o the following allergens:	
Allergen:	Type of Exposure: (i.e., air/skin contact/ingestion	Symptoms include but are not limited to: n, etc.): (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) ☐ Other (specify)
If my child was LIKEL	Y exposed to an allergen, for A	NY symptoms:
<u>*</u>	ne immediately	
•	NITELY exposed to an allergen, ne immediately	even if no symptoms are present:

OCFS-6029 (01/2021)
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

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:	1	1
Physician/HCP Authorization Signature:	Date:	1	1
Program Authorization Signature:	Date:	1	1

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:			
	I	1		
4. Name of Medication (including strength):	•	5. Amount/Dosage to I	oe Given:	6. Route of Administration:
7A. Frequency to be administered:				
OR 7B. Identify the symptoms that will necessitate adr possible, measurable parameters):				ust be observable and, when
8A. Possible side effects: See package ins	ert for co	omplete list of possible s	ide effects (paren	t must supply)
AND/OR				
8B: Additional side effects:				
9. What action should the child care provider take	if side ef	fects are noted:		
☐ Contact parent ☐ Contact ☐ Contac		care provider at phone	number provided	below
10A. Special instructions: See package inse	rt for cor	nplete list of special inst	ructions <i>(parent n</i>	nust supply)
AND/OR				
10B. Additional special instructions: (Include any concerns regarding the use of the medication as it	relates t	related to possible inter to the child's age, allergi	actions with other es or any pre-exis	medication the child is receiving or sting conditions. Also describe
situation's when medication should not be adminis	tered.) _			
11. Reason for medication (unless confidential by	law):			
12. Does the above named child have a chronic plor more and requires health and related services of	nysical, c of a type	fevelopmental, behavior or amount beyond that r	al or emotional co equired by childre	ondition expected to last 12 months on generally?
☐ No ☐ Yes If you checked yes, complete (#3	3 and #3	5) on the back of this fo	rm.	
13. Are the instructions on this consent form a chamedication is to be administered?	nge in a	previous medication ord	ler as it relates to	the dose, time or frequency the
☐ No☐ Yes If you checked yes, complete (#3	34 -#35)	on the back of this form.		
14. Date Health Care Provider Authorized: / /		15. Date to be Disco	ntinued or Length	of Time in Days to be Given:
16. Licensed Authorized Prescriber's Name (pleas	e print):	17. Licensed	Authorized Preso	criber's Telephone Number:
18. Licensed Authorized Prescriber's Signature:		I		

MEDICATION CONSENT FORM CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instauthorized prescriber write 12pm?)		c time to	administer	the medication? (For example, did the license	ıd
Write the specific time(s) the child day care	program is to administer	the med	ication (i.e.:	: 12 pm):	
20. I, parent, authorize the day care progra	m to administer the medic	ation, as	s specified o	on the front of this form, to (child's name):	
21. Parent's Name (please print):		22 Da	te Authorize	od!	
21.1 diones wante (piease pinn).		l .	/	su.	
23. Parent's Signature:					
CHILD DAY CARE PROGRAM CO	OMPLETE THIS SEC	TION (#24 - #30)	
24. Program Name: 25. Facility ID Number:				26. Program Telephone Number:	
27. I have verified that (#1 - #23) and if app this medication has been given to the day of	L blicable,(#33 - #36) are cor care program	mplete. I	My signature	l e indicates that all information needed to give	
28. Staff's Name (please print):	Programm		29. Date F	Received from Parent:	
30. Staff Signature:					
X					
ONLY COMPLETE THIS SECTION (# PRIOR TO THE DATE INDICATED IN	31 - #32) [F THE PARE (#15)	NT RE	QUESTS 1	TO DISCONTINUE THE MEDICATION	
31. I, parent, request that the medication in		rm be di	scontinued		
Once the medication has been discontinue	d. I understand that if my	child rea	uires this m	(Date) redication in the future, a new written medication	on
consent form must be completed. 32. Parent Signature:	,				· · ·
X					
LICENSED AUTHORIZED PRESC	RIBER TO COMPLE	TE. AS	S NEEDE	D (#33 - #35)	
33. Describe any additional training, proced					
34. Since there may be instances where the frequency until the medication from the pre- the administration of the prescription to take	vious prescription is comp	ew presoletely us	cription for c sed, please i	changes in a prescription related to dose, time indicate the date you are ordering the change	or in
DATE: / /					
By completing this section, the day care pronew prescription has been filled.	ogram will follow the writte	n instruc	ction on this	form and not follow the pharmacy label until the	he
35. Licensed Authorized Prescriber's Signa	iture:				
X					

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