### **Special Health Care Needs**

Date:
Dear Parent/Guardian,
According to the New York State Office of Children and Family Services Health and Infection Control Regulations, your child,, has been identified as a child with specia health care needs.
In order to comply with the Health and Infection Control Regulations, you must submit:
<ol> <li>Individual Health Care Plan For A Child With Special Health Care Needs Form or specific individual plan related to the identified special health care need, such as:</li> <li>Food Allergy &amp; Anaphylaxis Emergency Care Plan</li> <li>Asthma Action Plan</li> <li>Seizure Plan</li> <li>Diabetes Management Plan</li> </ol>
Written Medication Consent Form for each medication that may be required as stated on your child's medical statement. If you feel your child does not need medication while in care, you will need submit a note from your child's health care provider stating that your child may attend child care and that no medication is needed. The note must be dated, signed, and stamped by your child's health care provider.
Unfortunately, if we do not receive this information by, your child will not be able to continue to attend our program.
Thank you for your attention regarding this matter and for supporting us to ensure the health and safet of your child while attending our program.
*
My signature below indicates that I have read and understand the information that I must submit.
Parent's Name (please print):
Parent's Signature:
Date:
Child Care Program's Name (please print):
Child Care Program Director's Name (please print):
Child Care Program Director's Signature:

# 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:

following health care plan to meet the indiv	vidual needs of:
CHILD NAME:	CHILD DATE OF BIRTH:
NAME OF THE CHILD'S HEALTH CARE PROVIDER	R: Physician  Physician Assistant  Nurse Practitioner
Describe the special health care needs of health care provider. This should include information shared post enrollment.	this child and the plan of care as identified by the parent and the child's nformation completed on the medical statement at the time of enrollment or
Identify the caregiver(s) who will provi	de care to this child with special health care needs:
Caregiver's Name	Credentials or Professional License Information (if applicable)

Signature of Parent:

X

## 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. 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 TELEPHONE NUMBER: FACILITY ID NUMBER: PROGRAM NAME: DATE: CHILD CARE PROVIDER'S NAME (PLEASE PRINT): 1 CHILD CARE PROVIDER'S SIGNATURE: X Yes 🗌 No  $\square$ I agree this Individual Health Care Plan meets the needs of my child. 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 No information to non-child care staff. Yes

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.

My child is reactive to the following allergens:  Type of Exposure:  Allergen: (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         ☐ 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)		

OCFS-6029 (01/2021)		
Date of Plan:	1	1

## 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:			
,			71
		175%	
			16
EMERGENCY CONTACTS – CALL 911		1-01	
	<u> </u>		
Ambulance: ( ) -			
Child's Health Care Provider:	Phone #: (	)	-
Parent/Guardian:	Phone #: (	)	-
CHILD'S EMERGENCY CONTACTS			
Name/Relationship:	Phone#: (	)	-
Name/Relationship:	Phone#: (	)	<del>-</del>
Name/Relationship:	Phone#: (	)	_
Parent/Guardian Authorization Signature:	Date:	1	1
Parent/Guardian Authorization Signature:  Physician/HCP Authorization Signature:	Date:	1	1

#### 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:

Food Allergies will be posted in a discreet location visible to staff involved in the care of child.

Food Allergies will be reviewed routinely with all staff involved with the care of the child.

Prevent exposure to foods in which the child is allergic.

- Always read food labels.
- Children & Staff must wash hands with soap and water before and after eating.

Child will be supervised while eating and will not be allowed to share food.

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#: (	)	72
Parent/Guardian Authorization Signature:	Date:	1	I
Physician/HCP Authorization Signature:	Date:	1	1
Program Authorization Signature:	Date:	1	1