

Lakeland Children's Center
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Dear Parent / Guardian,

According to the NYS Office of Children and Family Services Health and Infection Control Regulations, your child has been identified as a child with special health care needs.

In order to comply with the Health and Infection Control Regulations, you must submit:

1. Individual Health Care plan for a Child with Special Health Care Needs including care plans for any of the following:
 - a. Food Allergy & Anaphylaxis Emergency Care Plan
 - b. Asthma Action Plan
 - c. Seizure Action Plan

Any child requiring medication on site will be required to have:

1. Written Medical Consent form for EACH medication
 - If you feel your child does not need medication while in our care, you will need to submit a note from your child's health care provider stating he/she may attend childcare and that no medication is needed. The note must be signed and stamped by your child's health care provider.

Unfortunately, if we do not receive all required items, your child will not be able to attend our program. This is a state regulation and therefore we must have all items in place **PRIOR TO THE FIRST DAY OF ATTENDANCE AT LCC.**

Thank you for your attention regarding this matter and for supporting us in our effort to ensure the health and safety of your child while attending the program.

My Signature below indicates that I have read and understand the information that is required for my child to attend LCC.

Parent Name (please print): _____

Parent

Signature: _____ Date: _____

Lakeland Children's Center

Beth O'Hara, Executive Director

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: 1) Individual children's food allergies will be posted in a discreet location visible to staff and volunteers involved in the care of the child. 2) Individual children's food allergies will be reviewed routinely with all involved in the care of the child. 3) Staff and volunteers will take steps to prevent a child's exposure to the foods to which the child is allergic including always reading food labels. 4) Children, staff and volunteers will wash their hands with soap and water before and after eating. 5) Tables and other surfaces will be cleaned well before and after eating. 6) Children will be supervised while eating. 7) Children will not be allowed to trade or share food, cups, utensils, napkins or food containers. 8) Parents of children with a food allergy must approve all foods offered to their child. 9) Children with a food allergy will not be offered food if its safety is unknown, food ingredients will always be reviewed. 10) Food will be stored out of the reach of young children. 11) The eating area will be separate from the play area. 12) Ingredients will be reviewed before using products in art, science, and other projects. 13) Parents will be notified in advance about activities that involve food. 14) Activities that involve food must be limited and must not include any child's known allergies. 15) Visual reminders of food allergy awareness (such as posters) will be displayed prominently.

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: / /

SEIZURE ACTION PLAN (SAP)



Name: _____ Birth Date: _____
Address: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify parent/emergency contact
- Contact school nurse at _____
- Call 911 for transport to _____
- Other _____

First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens _____
- Other _____

When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

When rescue therapy may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: VNS RNS DBS Date Implanted _____

Diet Therapy Ketogenic Low Glycemic Modified Atkins Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ 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 (<i>including strength</i>):	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: (<i>signs and symptoms must be observable and, when possible, measurable parameters</i>): _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (<i>parent must supply</i>)		
AND/OR		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact health care provider at phone number provided below <input type="checkbox"/> Other (<i>describe</i>): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (<i>parent must supply</i>)		
AND/OR		
10B. Additional special instructions: (<i>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.</i>) _____		
11. Reason for medication (<i>unless confidential by law</i>): _____		
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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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

Asthma Action Plan

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General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/healthcare provider _____ Phone numbers _____
 Physician signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Premedication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days.
- Change your long-term control medicine by _____
- Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- Take quick-relief treatment again.
- Change your long-term control medicine by _____
- Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if:

- Still in the red zone after 15 minutes.
- You have not been able to reach your physician/healthcare provider for help.
- _____

Call an ambulance immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath.
- Lips or fingernails are blue.