TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
2021/2022 MEDICAL FORM INSTRUCTIONS FOR EPI-PEN
*** PLEASE NOTE: We are unable to dispense Benadryl.**

According to New York State Office of Children and Family Services, these are the only forms that will be accepted and must be completed entirely. Unfortunately, School District forms cannot be accepted. All medical forms (a total of 10 pages) are due in our office no later than August 1st.

***These signatures are valid for one-year from date signed. ***

Please follow instructions below:

1. **Medical Report Form (1 Page): Must be filled out completely, signed, stamped and dated by Physician. Physical is not required if child has had one within the last 2 years.**

2. **Allergy/Anaphylaxis/Epi-Pen Emergency Plan (1 Page): Bottom portion must be filled out and signed by parent. Any information that does not apply, parent must draw a line through and initial. These signatures are valid for one-year from date signed.**

3. **Medication Consent Form (2 Pages): Physician must fill out in its entirety and sign bottom of page 1, parent must review for accuracy and sign top of page 2. Section #31-35 does not have to be completed unless applicable. *The information written on these pages MUST match the information printed on prescription label. (see below).***

4. **Individual Health Care Plan- Epi-Pen: (2 Pages)**

   - **Page 1: Must be filled out by parent in its entirety. *Parent must outline a detailed description of allergies including symptoms, when the epi-pen should be administered, instructions on use, and what steps should be followed after the epi-pen has been injected.**

   - **Page 2: Parent must sign and date bottom portion of form.**

5. **Individual Allergy and Anaphylaxis Emergency Plan: (3 Pages)**

   - **Page 1-3: To be filled out in its entirety and signed by both parent and Physician on Page 3.**

*******IMPORTANT*******

EPI-PEN WILL NOT BE ACCEPTED IF:

- **THE EPI-PEN IS EXPIRED**
- **THE EPI-PEN IS NOT IN THE ORIGINAL CONTAINER WITH THE CHILD'S NAME ON THE PRESCRIPTION LABEL**
- **THE (MEDICATION NAME/DOSAGE IF APPLICABLE) DOES NOT MATCH.**
  EXAMPLE: THE INFORMATION ON THE EPI-PEN AND PAPERWORK MUST READ EXACTLY THE SAME!! THERE WILL BE NO EXCEPTIONS.

All forms must be filled out according to instructions or they will not be accepted as per OCFS Regulations.

TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE PROGRAM
2021/2022 MEDICAL FORM

NAME OF CHILD:_____ **NAME OF SCHOOL:**_____

Medical Report of Child in Day Care

To Be Completed By Child's Physician, Physician's Assistant or Nurse Practitioner (Other Than A Relative)

Date of Birth: / / **Date of Last Exam:** / /

HEALTH SPECIFICS:	**COMMENTS:**
☐ Yes ☐ No Are there any allergies? If yes, specify what the child is allergic to.	
☐ Yes ☐ No Is medication regularly taken? (Specify drug & condition)	
☐ Yes ☐ No Is a special diet required? (Specify diet & condition)	
☐ Yes ☐ No Are there any hearing, visual or dental conditions requiring special attention?	
☐ Yes ☐ No Are there any medical or developmental conditions requiring special attention?	

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? ___ Yes ___ No

If yes, describe any additional training, procedures or competencies the day care program staff will need to care for this child._____

Date of most recent tetanus booster: / /

Summary of most recent physical (including special recommendations to Day Care Provider):

_____

_____

_____

At the time of the child's last exam and on my knowledge of the above named child, I find that he or she is free from contagious and communicable disease and is able to participate in day care.

☐ **Yes** ☐ **No**

Signature of Examiner: _____ **Address**:_____

Please Print Name: _____ **City, State, Zip**: _____

Title: _____**Phone**: _____ **Date**: ____/_____/_____

TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
ALLERGY /ANAPHYLAXIS /EPI-PEN EMERGENCY PLAN

Child's Name: _____ **Name of School:** _____

Child's Date of Birth: _____**Address:** _____

Child is allergic to: _____

The School Age Child Care Program may serve snacks manufactured in a facility that produces nuts. The School Age Child Care Program cannot guarantee that nuts will not be brought into the program. Refer to Parent Handbook regarding snack policy.

Prescribed Medication: Epi-Pen Auto Injector, Epi-Pen Jr, Epinephrine
Please note: The School Age Child Care Program is unable to dispense Benadryl.

It is the parent's responsibility to provide the School Age Child Care Staff with epi-pens in the original containers with the child's name on the label. The parent will ensure that the epi-pen is up to date and not expired. The parent will instruct the School Age Child Care Staff on the use of the epi-pen.

When to give EPINEPHRINE (Epi-Pen): AT ONSET OF SEVERE ALLERGIC REACTION/ ANAPHLAXIS.

SEVERE ALLERGIC REACTION/ ANAPHLAXIS : ITCHING, SWELLING, SNEEZING, COUGHING, HIVES, RASH, NAUSEA, ABDOMINAL CRAMPING, VOMITING, DIARRHEA, THROAT CLOSING, DIFFICULTY BREATHING, CHOKING, DIZZINESS, LOSS OF CONSCIOUSNESS.

SIDE EFFECTS OF EPI-PEN: SHAKINESS, INCREASED HEART RATE, POSSIBLE NAUSEA/ VOMITING.

HOW TO GIVE EPINEPHRINE (EPI-PEN)

1. **Remove inner epi-pen from outer casing.**
2. **Remove cap.**
3. **Jab into outer aspect of thigh and hold for 10 seconds.**

Note: Auto injector- no plunger to push

NOTE: PATIENT MUST BE TRANSPORTED TO EMERGENCY ROOM IMMEDIATELY AFTER ADMINISTRATION OF EPINEPHRINE!!

2ND DOSE OF EPINEPHRINE (EPI-PEN) MAY BE GIVEN 5-15 MINUTES AFTER 1ST DOSE IF SEVERE SYMPTOMS WORSEN BEFORE AMBULANCE ARRIVES.

Parent Request for SACC Staff to Administer Epi-Pen

I, hereby, request that my child, _____, be given the medication above as prescribed by the physician. I, the parent, authorize the Town of Smithtown School Age Child Care Staff to administer an epi-pen and agree that we will not hold liable any member of the School Age Child Care Staff or individual of official capacity who is directed by me (the parent) in administering the medication. I understand that my child is not able to attend the program when expired medication is on site.

_____ _____

Parent/Guardian Signature **Date**

***This signature is valid for one-year from date signed**

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 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.

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)

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 Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: X		

Signature of Parent:

X	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: / /
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: / /