TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
2021/2022 MEDICAL FORM INSTRUCTIONS FOR INHALER

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 6 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. Medication Authorization Form for Administration of Medication (1 Page): Bottom portion (Self Medication Release Form) must be signed and dated by parent. This signature is 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 the prescription label.* (see below).

4. Individual Health Care Plan- Inhaler/Asthma: (2 Pages):

    - Page 1: Must be filled out by parent in its entirety. *Parent must outline a detailed description of symptoms, when the inhaler should be given, instructions on use, and what steps should be followed after the child administers his/her inhaler.*

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

****IMPORTANT****

INHALER WILL NOT BE ACCEPTED IF:

- **THE INHALER IS EXPIRED**
- **THE INHALER 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 INHALER 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
Medication Authorization Form For Administration of Medication

Name of Child: _____________________________ **Name of School:**____________________________

Child's Date of Birth: _________________ **Address**: ____

Diagnosis: Asthma

Medication:

____

____

Instructions:

____

____

===

Self Medication Release Form

I, hereby, request that my child, ____ be given the medication above as prescribed by the physician. I, the parent or guardian authorize the School Age Child Care Staff to provide my child with the medication and agree that we will not hold liable any member of the School Age Child Care Staff or an individual of official capacity who is directed by us to provide the child the said medication.

It is my, (parent's) responsibility to provide the School Age Child Care Staff with inhalers in the original containers with the child's name on the label. I, the parent will ensure that the inhaler is up to date and not expired. I understand that my child/children are not able to attend the program if medication is expired or not in the original container.

_________________________________ _____________________________

Parent/Guardian Signature **Date**

The above 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: