

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY ACTION CARD

CHILD'S FULL NAME: _____ DATE OF BIRTH: / / GENDER: _____

KNOWN ALLERGENS: _____ ASTHMA?
YES NO

HISTORY OF ANAPHYLAXIS?
YES NO

POTENTIAL SYMPTOMS:

MEDICATION/DOSAGE/LOCATION:

EX PO SU RE AC TI ON PL AN	1.	
	2.	
	3.	
	4.	

RISK MANAGEMENT STRATEGIES:

NOTES:

EMERGENCY CONTACT(S):

PROVIDER SIGNATURE:
X

DATE:
/ /

SIGNATURE – PARENT OR PERSON LEGALLY RESPONSIBLE:
X

DATE:
/ /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child: _____	Date of Birth: / /	Date of Examination: / /
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Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). Yes No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	5 th Date / /
Polio (IPV or OPV)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Haemophilus influenzae type B (Hib)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date OR 1 st Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date / /	2 nd Date / /	3 rd Date / /	4 th Date / /	
Hepatitis B	1 st Date / /	2 nd Date / /	3 rd Date / /		
Measles, Mumps and Rubella (MMR)	1 st Date / /	2 nd Date / /			
Varicella (also known as Chicken Pox)	1 st Date / /	2 nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: / /	Mantoux Results: Positive Negative mm
TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.	
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.	
Lead Screening Date: / /	
Attach lead level statement	
Lead Screening (Include All Dates and Results)	
1 year / /	Result: mcg/dL Venous Capillary

2 years / / Result: _____ mcg/dL Venous Capillary

Most recent date of lead screening (if different from above):

_____ / / Result: _____ mcg/dL Venous Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must provide the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics

Comments

Are there allergies? (Specify)	Yes	No	
Is medication regularly taken? (Specify drug and condition)	Yes	No	
Is a special diet required? (Specify diet and 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?	Yes	No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. Yes No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	() - / /
	Phone Date

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:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ()
CHILD CARE PROVIDER’S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER’S SIGNATURE: X		

I agree this Individual Health Care Plan meets the needs of my child. Yes No

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 information to non-child care staff. Yes No

Signature of Parent:

X	DATE: / /
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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: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

	PROGRAM NAME:		ADDRESS:		PHONE NUMBER: () -		
	CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:				DATE OF BIRTH: / /		GENDER:
	CHILD'S HOME ADDRESS:						
	NAME OF PERSON ENROLLING CHILD:			RELATIONSHIP TO CHILD: Parent Guardian Caretaker Relative ____ Other ____			
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () - EMAIL ADDRESS:				ok to text			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER		OTHER PHONE NUMBER / EMAIL	
	PRIMARY CONTACT:		Yes No	() - ok to text		() - ok to text	
			Yes No	() - ok to text		() - ok to text	
		Yes No	() - ok to text		() - ok to text		
FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /				FOR PROGRAM USE ONLY DATE OF DISENROLLMENT: / /			

CHILD'S FULL NAME:				DATE OF BIRTH: / /	
Check boxes below to indicate if your child has any special needs/services:				None	
Early Intervention/Special Education		Occupational Therapy	Speech/Language		Physical Therapy
Allergies (Please list)					
Other					
Please provide information here AND discuss with your child care provider:					
CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:				PHONE NUMBER: () -	
PREFERRED HOSPITAL:				PHONE NUMBER: () -	
CHILD'S DENTAL CARE:				PHONE NUMBER: () -	
<p>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/</p>					

AGREEMENTS

- | | | |
|--|-----|----|
| | Yes | No |
| • I consent to emergency medical treatment for my child..... | Yes | No |
| • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... | Yes | No |
| • I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... | Yes | No |
| • I provided information on my child's special needs to the program to assist in caring for my child..... | Yes | No |
| • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... | | |
| • I agree to review and update this information whenever a change occurs and at least once every year..... | | |

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:

DATE: / /