

CCSD Childcare Individual Allergy Action Plan

If your child has an allergy that could require emergency medical treatment such as an Epi Pen, you need to supply the emergency medication to the school and complete the attached paperwork.

Required Forms:

- Individual Allergy & Anaphylaxis Emergency Plan
- Individual Health Care Plan for a Child with Special Health Care Needs
- Medication Consent Form

How to Complete the Forms:

- **Individual Allergy & Anaphylaxis Emergency Plan:** In conjunction with your health practitioner, complete the form giving us detailed information about your child's allergens and signs of possible exposure. **Parent and health care provider sign the form (page 3).**
- **Individual Health Care Plan for a child with Special Health Care Needs:** Please draft instructions for the daycare staff to follow in the event of a known exposure or signs of an allergic reaction appear. It should be a step-by-step guide. I will use your notes to draft a final document that will be sent home for approval. You will sign the final draft.
- **Medication Consent Form:** This is a 2-page document (pages 6 & 7 of this packet). You need to have **your health care provider complete and sign** a separate form for each medication we will have. **You will sign** the form in section #19-23.

Please let me know if you have any questions.

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

Instructions: *Please consult health care practitioner, complete form, parent & health provider sign. pg. 3*

- 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)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> Other (specify)
		<input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Pale or bluish skin, faintness, weak pulse, dizziness <input type="checkbox"/> Tight or hoarse throat, trouble breathing or swallowing <input type="checkbox"/> Significant swelling of the tongue or lips <input type="checkbox"/> Many hives over the body, widespread redness <input type="checkbox"/> Vomiting, diarrhea <input type="checkbox"/> Behavioral changes and inconsolable crying <input type="checkbox"/> 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:

- All staff are trained in the assessment and treatment of allergic reactions.
- All staff are aware of students with known allergies.
- Students will only eat food parents provide.
- Food of students with allergies is stored and prepared separate from the other children’s food.
- Students and staff will wash hands after eating.
- Staff will seat children with allergies separately from students who are eating foods with known allergens.
- Staff is vigilant to prevent sharing of food.
- Attention is given to students who still put toys in their mouths; children with allergies should be given their own 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#: () -
Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature	Date: / /
Program Authorization Signature.	Date: / /

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:	<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> 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.

**** Please draft instructions you want daycare staff to follow in the event of exposure to allergen or signs of a reaction develop.**
- Ms. Sandy will create a formal document using your notes and send it to you for approval.

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
WRITTEN MEDICATION CONSENT FORM



- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

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: <input type="checkbox"/> 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:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> 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 situations when medication should not be administered.) _____		
11. Reason the child is taking the 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 require 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-#34 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 #35-#36 on the back of this form.		
14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given (<i>this date cannot exceed 6 months from the date authorized or this order will not be valid</i>):	
16. Prescriber's name (please print):	17. Prescriber's telephone number:	
18. Licensed authorized prescriber's signature: X		

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
WRITTEN MEDICATION CONSENT FORM

PARENT/GUARDIAN MUST 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 prescriber write 12pm?) Yes N/A No

Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm):

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____
(child's name)

21. Parent or legal guardian's name (please print):

22. Date authorized:

23. Parent or legal guardian's signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:

CCSD childcare

25. Facility ID number:

733098

26. Facility telephone number:

845 213-9489

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. Authorized child care provider's name (please print):

Sandra Condon

29. Date received from parent:

30. Authorized child care provider's 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/legal guardian, 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 or Legal Guardian's Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:

X

35. 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 by which you expect the pharmacy to fill the updated order.

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.

36. Licensed Authorized Prescriber's Signature:

X