Capital Church Program Enrollment Form

Child's Name_____

D.O.B._____School your child currently attends:_____

Program enrolling for:(Circle all that apply) Summer Camp / After Care / 3 year old/ 4 year old

Will your child be traveling to : (Circle One) After Care by: BUS / CAR

Parent /Guardian Name (Primary contact)_____

Parent Occupation/Employer_____

Employer Phone Number_____

Parent email address_____

Parent/Guardian Name (Secondary contact)_____

Parent Occupation/Employer_____

Employer Phone Number_____

Parent email address_____

Please tell us a little bit about your child: nicknames, hobbies, special skills, extra-curricular activities, etc._____

_____

List any allergies your child has:_____

How did you hear about our program:_____

I have received and read the entire parent handbook: (Circle One) YES / NO

FOR OFFICE USE: Date Enrolled_____Registration pd._____

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

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: ( ) - ☐ ok to text **EMAIL ADDRESS:**	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: / /

OCFS-LDSS-0792 (08/2019) REVERSE

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: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- 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…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

Rr4f cvOCFS 6013 (2/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSPORTATION CONSENT FORM

Child Day Care Programs

Provider Name: Jennifer Karampatsos Facility ID Number: 928516

Program Name: Capital Church

This form may be used to meet the regulatory requirement to obtain written consent from the parent of a child for any transportation provided or arranged for by a caregiver, and to inform the parent when the person who is providing transportation changes. This form is not the Transportation Plan.

Parents whose children receive transportation services must receive, at the time of enrollment of their children, a copy of the program's transportation plan. If the plan is amended, parents must receive a copy of the amended plan prior to its start date.

It is recommended that a separate Transportation Consent Form be completed for each child.

☐ I have been informed of, and agree to, the transportation plan of the above child care program.

Transportation Plan is attached to this Transportation Consent Form (Yes / No) *circle one*

Date of Transportation Plan _____

☐ I give permission for my child *(name)* _____

to be transported by *(caregiver names and/or transportation contractor arranged for by the program)* _____

_____

_____

hfrAt the following times *(check all that apply)*:

☐ Only as recorded on the posted transportation schedule for my child

☐ Other *(explain)*

_____

_____

_____

By signing this form I am giving consent for the above described transportation services.

Parent Printed Name: _____

Parent Signature: **X** _____

Date _____

OCFS-LDSS-4433 (Rev. 06/2019)

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: / /

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

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: / /

SPECIAL NEEDS PLAN FOR A CHILD

WITH ENVIRONMENTAL OR SEASONAL ALLERGIES

Child's Name: _____ Child's DOB: _____

Does this child have asthma? **Yes** **No** Child's Weight: _____

This plan is designed to be completed for a child with seasonal/environmental allergies that are not life threatening and do not require emergency medication. *By completing this form, staff will have a better understanding of the child's allergy, including triggers, symptoms and what treatment may be required. Any required medication will be stored per the programs approved Health Care Plan.*

- The abovenamed child has a diagnosis of (please circle):
  Seasonal Allergies **Environmental Allergies** Other: _____

- Is the child on **medication** for the allergy? **Yes** **No**
  - If you answered **Yes** above, is the medication needed in care? **Yes** **No**
    *See written Medication Consent form for medication(s) needed in care.
  - Is this medication an emergency medication (Epinephrine, Diphenhydramine, Inhaler, Nebulizer)? **Yes** **No**
    *If you answered **Yes** above, you must complete the **OCFS-LDSS-6029**

- **Known triggers** for child's allergy (circle all that apply):

Animals/Pet Dander Chemical Odors Flowers Grass Dust Mold
Perfumes/Scents Season Changes (Specify: _____) Pollen
Other: _____

- Typical **signs & symptoms** the child experiences with the allergy (circle all that apply):

Runny Nose Sneezing Coughing Congestion Itchy/watery eyes Puffy eyes
Itchy Throat Post-Nasal Drip Other: _____

Do you consider these signs/symptoms to be **mild or severe**? _____

How frequent are these symptoms? **Daily** **Intermittent** **Infrequent**

- Strategies to reduce the risk of exposure to the child's known triggers include:

_____
_____
_____
_____

- Are there any accommodations needed in care for the child or special instructions for staff (explain below or write N/A):_____

_____
_____
_____
_____

- The program staff who will care for the child with special health care needs are:

Staff:	Credentials:
_____	_____
_____	_____
_____	_____
_____	_____

- Does staff need any additional training to care for the child? **Yes** **No**
    - **If Yes, specify:** _____

- Reasons to contact the parent: _____
- **Reasons to call 911**: Difficulty breathing or signs/symptoms of anaphylaxis.

This plan was developed in close collaboration with the child's parent/guardian and the child's health care provider. The program understands their responsibility to follow this plan and assure that the caregivers listed above understand the plan, as well as maintain the appropriate credentials needed to care for the child.

Child's Health Care Provider: _____ Phone #:_____
Health Care Provider Signature: _____

Provider/Program Name: _____
License/Registration #: _____ Program Telephone #: _____
Child Care Provider's Name (please print): _____
Child Care Provider's Signature: _____ Date: _____

Name of Parent/Guardian: _____ Phone #: _____
Signature of Parent/Guardian: _____ Date:_____

SPECIAL NEEDS PLAN FOR A CHILD WITH ASTHMA

Child's Name: _____ **DOB:** _____

Child's Health Care Provider: _____

This plan is designed to be completed in place of the Individual Health Care Plan for a Child with Special Health Care Needs for a child with asthma. By completing this form, staff will have a better understanding of the child's asthma triggers, early warning signs, and symptoms of an asthma episode, as well as actions to take if the child has an asthma episode while in care.

- Does the child take **medication** at home for their asthma? **Yes** **No**
    - If you answered **Yes** above, is this medication needed in care? **Yes** **No**
      *****See written Medication Consent form for medication(s) needed in care
- Does the child use a **flowmeter** to monitor need for medication? **Yes** **No**
    - If you selected Yes above, clarify what reading requires rescue medication _____ and what reading requires emergency care (calling 911) _____
- **Known triggers** for this child's Asthma (circle all that apply):

  Colds Mold Exercise Pollens Excitement Strong odors
  Smoke Animals Grass Flowers Dust Weather changes
  Air fresheners/cleaners Foods (specify) _____
  Other (specify) _____

- **Activities** that may exacerbate the child's asthma (circle all that apply):

Outdoors	**Indoors**
Field trip to see animals	Kerosene/wood stove heated rooms
Running	Art projects with chalk, glue, fumes
Gardening	Sitting on carpets
Jumping in leaves	Pet care
Outdoors on cold/windy day	Recent pesticide application in facility
Playing in freshly cut grass	Painting

  Other (specify) _____

- **Early Warning Signs** for this child's asthma (circle all that apply):

Behavior changes	Wheezing, coughing	Fatigue
Rapid breathing	Stuffy or runny nose	Headache
Watery eyes, itchy throat	Other (specify) _____	

- **Typical signs or symptoms** of the child's asthma episodes (circle all that apply):

Fatigue	Flaring nostrils	Red, pale or swollen face
Grunting	Restlessness	Mouth open (panting)
Wheezing	Breathing faster	Persistent coughing
Agitation	Sucking in chest/neck	Gray or blue lips or fingernails
Difficulty playing, eating, drinking, talking	Other _____	

- The program **staff** who will provide care to this child with special health care needs are:

Staff:	**Credentials:**

- The child's parents/guardian will provide staff with training on the use of any emergency medications required (inhaler or nebulizer), as well as the use of a flowmeter (if needed). Additional training the staff may need includes (explain below or write N/A): _____

GENERAL PLAN OF ACTION IF CHILD IS HAVING AN ASTHMA EPISODE:

1. Remove child from any known triggers.
2. Follow instructions on child's *Written Medication Consent Form* (if applicable).
3. Notify parents immediately if medication is administered or if the child does not have medication on site (parents should pick up ASAP).
4. Get emergency medical help if:
   - The child does not have medication on site, but symptoms are worsening before parents arrive.
   - The child does not improve 15 minutes after treatment and family cannot be reached.

     OR
   - After receiving a treatment, the child:
     - Is grunting or working hard to breathe
     - Won't play
     - Is breathing fast at rest (>50/minute)
     - Has gray or blue lips or fingernails
     - Has trouble walking or talking
     - Cries more softly and briefly
     - Has nostrils open wider than usual
     - Is hunched over to breathe
     - Has sucking in of chest/neck
     - Is extremely agitated or sleepy
     - Passes out or stops breathing

This plan was developed in close collaboration with the child's parent/guardian and the child's health care provider. The program understands their responsibility to follow this plan and assure that the caregivers listed above understand the plan, as well as maintain the appropriate credentials needed to care for the child.

Provider/Program Name: _____

License/ Registration #: _____ **Program telephone #:** _____

Child Care Provider's Name *(please print):* _____

Child Care Provider 's Signature : _____ **Date:**_____

Signature of Parent/Guardian : _____ **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 *(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 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: / /