

# North Shore Youth Council

P.O. Box 1286, Rocky Point, NY 11778 - Phone: (631) 744-0207 - Fax: (631) 744-3565 - [www.nsync.com](http://www.nsync.com)

Dear Parents/Guardians,

Thank you for registering your child for North Shore Youth Council's School Age Child Care program! Your registration form for your child indicates that he/she may require the use of an EpiPen, AuviQ (along with Benadryl), or an asthma inhaler. NSYC's SACC program has been granted the ability to administer such presented emergency medication.

According to the rules and regulations of the NYS Office of Children and Family Services, if the use of the above mentioned emergency medication is so indicated on a registration form, the provider (NSYC) must have written permission and written directions from both the parent/guardian and the medical provider to administer such medications.

- ❖ An Individual Health Care Plan must be completed in advance by you and reviewed and signed by the program's site supervisor.
- ❖ A Written Medication Consent Form must be completed and signed by:
  - 1. Health Care Provider – Must fill out #1-18 and #33-36
  - 2. Parent/Guardian – Must fill out #19-23
  - 3. NSYC Site Supervisor – Must fill out #24-30
- ❖ A Written Medication Consent Form must be completed for EACH medication your child requires on site. For example, if your child needs to have Benadryl AND an EpiPen on site, TWO (2) Written Medication Consent Forms must be completed.
- ❖ All medication brought to the program MUST be in its original box with the original pharmacy label. Over the counter medications MUST be unopened and labeled with the child's name on it. Medication samples will not be accepted. The expiration date on the medication should be no less than six months from your child's start date.

If your child has an allergy, medical condition, or asthma and **WILL NOT** require medication at the program site, it is necessary for you to complete and return the NSYC Medication Exempt Form.

The Individual Health Care Plan, Written Medication Consent Form, and medication **MUST** be on site at your child's program **PRIOR** to them attending. **If you need your child to attend the program and DO NOT have the forms completed, please fill out the Medication Exempt Form.** If you fill out the Medication Exempt Form, this means your child's medication will not be on site. Once you have the required forms completed, bring them to the program with the required medication. The Medication Exempt Form will then be discarded.

If you have any questions, please feel free to contact your program's site supervisor!

Thank you,

*North Shore Youth Council*

North Shore Youth Council is funded in part by the Town of Brookhaven, the County of Suffolk, the State of New York, the North Shore Consortium, and public and private donations.

*NSYC is not responsible for loss/damage to personal property and/or injury while on premises or participating in programs.*

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## Medication Exempt Form

If your child has a medical condition, asthma, or an allergy and does **NOT** require medication during the time in NSYC's SACC Program, please complete this form. This form must be completed and received before your child starts our program.

<b>Child's Name:</b>	
<b>Date of Birth:</b>	
<b>Grade:</b>	
<b>School:</b>	
<b>Allergy:</b>	
<b>Asthma:</b>	
<b>Medical Condition:</b>	

My child, \_\_\_\_\_  
will **NOT** require the administration of any medication while in care at the  
NSYC. If my child is in distress, 911 will be called along with the parent.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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: _____		
<b>OR</b>		
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)		
<b>AND/OR</b>		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent <span style="margin-left: 100px;"><input type="checkbox"/> Contact prescriber at phone number provided below</span>		
<input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply)		
<b>AND/OR</b>		
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: <b>X</b>		

NEW YORK STATE  
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**WRITTEN MEDICATION CONSENT FORM**

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:

25. Facility ID number:

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

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**

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.

Allergy To:
Symptoms: (Circle all that apply)
Mouth - Itching      tingling      metallic taste      swelling of lips      tongue      mouth
Skin - Itchy rash      hives      swelling of eyes      swelling of face or extremities
Abdominal - Nausea      cramping      vomiting      diarrhea
Throat - Hoarseness      hacking cough      tightening and/or swelling of throat
Lungs: Shortness of breath      repetitive coughing      wheezing
Heart - Fainting      paleness      blueness of lips or fingernail beds

**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.

The North Shore Youth Council has staff members who possess a current certification in first aid and cardiopulmonary resuscitation (CPR) appropriate to the ages of the children in care
1. At first sign of symptoms, notify parent. Administer Anti-Histamine medication if ordered for symptoms on the previous page. If ordered, administer Epi-Pen or Epi-Pen Jr.
2. For severe allergic reactions - seek emergency care by calling 911. A staff member must accompany the child until family is present
Other:

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: <b>X</b>		

**Signature of Parent:**

<b>X</b>	Date:
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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.

Asthma
Symptoms:(Circle all that apply)
Rapid breathing      wheezing      open mouth breathing      flaring nostrils      grunting      face reddened
swollen dark circle      under the eye      persistant cough      complaining of chest pains      tightness in chest      paled
restlessness      agitation      fatigue.
Treatment: Avoid known triggers (Circle all that apply)
Grass      tree pollen      flowers      dust      smoke      strong odors      mold      excitement
exercise      animals      illness      weather changes
Other:

**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.

The North Shore Youth Council has staff members who possess a current certification in first aid and cardiopulmonary resuscitation (CPR) appropriate to the ages of the children in care
1. Notify parent and administer medication if ordered for symptoms on the previous page. Children will be encouraged to rest and take slow breaths.
2. If there are no signs of improvement within 15-20 minutes, seek emergency care by calling 911. A staff member must accompany the child until family is present
Other:

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: <b>X</b>		

**Signature of Parent:**

<b>X</b>	Date:
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PLACE  
PICTURE  
HERE

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

THEREFORE:

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**



**LUNG**

Shortness of breath, wheezing, repetitive cough



**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness



**THROAT**

Tight or hoarse throat, trouble breathing or swallowing



**MOUTH**

Significant swelling of the tongue or lips



**SKIN**

Many hives over body, widespread redness



**GUT**

Repetitive vomiting, severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

OR A  
**COMBINATION**  
of symptoms  
from different  
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS**



**NOSE**

Itchy or runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

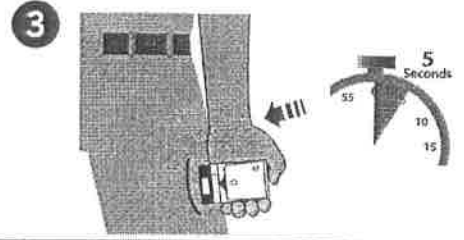
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_

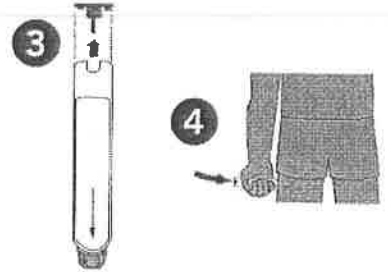
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



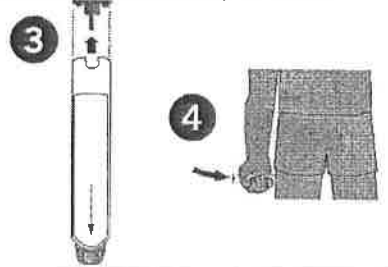
## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



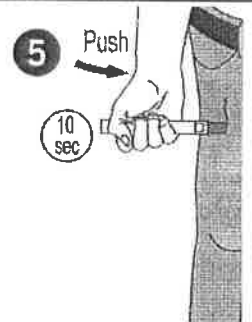
## HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_