YMCA of Greater Rochester
BASP Medical Paperwork Guide

As a licensed child care provider, the YMCA is required by the New York State Office of Children and Family Services (OCFS) to collect specific medical paperwork before your child can attend the Before & After School Program. Whether your child has **allergies, asthma, a medical diagnosis, or takes any medication**, this guide will walk you through exactly what's required.

In this guide, you'll find:

- A flowchart to help you decide what's needed
- Detailed instructions on how to fill out every form correctly
- Examples of exactly what to write, and what to avoid

We've broken it down by category: **Allergies, Asthma, and Other Medical Needs**, with real-life examples and step-by-step instructions to make the process as simple and clear as possible. For example:

- If you listed a *seasonal allergy* like pollen or grass, you'll still need to complete the required forms, even if your child doesn't take medication.
- If your child has *asthma* and uses an *inhaler*, we'll show you how to submit the medication consent and individual health care plan.
- If your child has a diagnosed medical condition like ADHD, diabetes, seizure history, or uses a medical device, you'll find detailed guidance on what to include on their health care plan.

Important: If you listed *any allergy* during registration, **regardless of severity**, you are required to complete specific OCFS forms, unless you contact us to officially remove that allergy from your child's record. This includes allergies to foods, animals, environmental factors, medications, and more.

Many YMCA BASP sites are not **MAT-certified**, which means staff are **not permitted to administer most medications**. The only medications we are legally allowed to give are:

- Epinephrine auto-injectors (e.g., EpiPen or Auvi-Q)
- Rescue inhalers (for asthma emergencies)
- Benadryl (when used as part of an emergency allergy response plan)

Medications like ADHD pills, Claritin, and Insulin cannot be administered at non-MAT programs, per OCFS regulations. Children with diabetes must be able to self-manage their condition or have a communication plan in place with their parent/guardian. If your child requires *daily or time-sensitive medication* that is not classified as emergency use, we will work with you to explore options, but in most cases, those medications cannot be administered during program hours.

In some cases, **provider-issued documents may be accepted in place of OCFS forms**, as long as they include all required information and signatures.

All medical paperwork must be submitted before your child's first day at the program. Email completed forms back to your Program Director or upload forms to the Parent/Guardian Medical Paperwork Portal at rochesterymca.org/child-care/basp.

OCFS MEDICAL PAPERWORK

ALLERGIES AND/OR ASTHMA

CHILD HAS AN ALLERGY AND WILL HAVE EMERGENCY MEDICATION KEPT AT SITE (EPI-PEN, AUVI-Q, BENADRYL)	→ FORM #1 OCFS 7006 INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL NEEDS	+ FORM #2 OCFS 6029 ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN	+ FORM #3 OCFS 7002 MEDICATION CONSENT FORM	
CHILD HAS A MILD, NON-ANAPHYLACTIC ALLERGY AND NO MEDICATION WILL BE KEPT AT SITE	→ FORM #1 OCFS 7006 INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL NEEDS	+ FORM #2 OCFS 6029 ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN	OR EMAIL US TO REMOVE THE ALLERGY FROM YOUR CHILD'S RECORD (NOT RECOMMENDED)	
CHILD HAS ASTHMA AND WILL HAVE AN INHALER AT SITE	→ FORM #1 OCFS 7006 INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL NEEDS	+ FORM #2 OCFS 7002 MEDICATION CONSENT FORM		
CHILD HAS MILD ASTHMA AND WILL NOT HAVE AN INHALER AT SITE	→ FORM #1 OCFS 7006 INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL NEEDS			

OTHER MEDICAL CONCERNS

ADHD AND/OR ANXIETY	HEARING IMPAIRMENT	
AUTISM SPECTRUM DISORDER	USES WHEELCHAIR	→ FORM #1 OCFS 7006 INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL NEEDS
DIABETES	BEHAVIORAL CONCERNS	
SEIZURES/ EPILEPSY	OTHER MEDICAL DIAGNOSIS	

OCFS Medical Paperwork Overview

1. **OCFS 6029 - Individual Allergy and Anaphylaxis Emergency Plan**
   - This form is required for **any child with a known allergy**, regardless of severity (e.g., food, insect, medication, seasonal, or environmental).
   - It must be completed in partnership with your child's health care provider and outlines:
     - What the child is allergic to
     - Symptoms to watch for
     - Prevention strategies
     - Emergency response steps
   - This form is required **even if your child does not take allergy medication** at the program.
   - **Low-risk or minor allergies** (like penicillin or lactose) may be removed from your YMCA account to avoid unnecessary paperwork.
   - If a parent/guardian chooses **not to provide epinephrine**, the child's provider must clearly state on this form that epinephrine will not be provided or required at site. even if the allergy has a history of anaphylaxis.
   - If **epinephrine is checked on this form** and the medication is not supplied, your child cannot attend until the auto-injector is received or the form is corrected.
   - This form must be signed by both the parent/guardian and the child's health care provider.

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2. **OCFS 7006 - Individual Health Care Plan for a Child with Special Health Care Needs**
   - This form is required for any child with an ongoing medical condition that may affect their health, safety, or daily participation in the program. This includes but is not limited to **asthma, ADHD, seizures, diabetes, ASD, hearing/mobility needs or any other medical condition that may require accommodations**.
   - This form helps the YMCA understand your child's medical needs and outlines:
     - What condition your child has
     - Signs or symptoms to watch for
     - Daily care or support needed
     - Emergency procedures for staff to follow
     - Accommodations or restrictions during activities
   - This form is still required **even if no medication is kept at site**.
   - Please be specific when describing what staff should do. For example:
     - Instead of: "Use inhaler as needed."
     - Write: "Use rescue inhaler if child is wheezing, coughing, or struggling to speak after physical activity."
   - If your child self-carries an inhaler or EpiPen, be sure to note where it will be kept and that the child has been instructed in proper use.
   - This form must be **signed by both the parent/guardian and the child's health care provider**.

3. **OCFS 7002 - Medication Consent Form**
   - This form is required for each emergency medication that will be stored and used at the program (e.g., EpiPen, Auvi-Q, rescue inhaler, Benadryl).
   - One form is needed per medication—you must complete a separate form for each.
   - It must include:
     - Medication name and dosage
     - How and when to give it
     - Symptoms that require use
     - Start/end dates
     - Known side effects
   - This form is only accepted for emergency medications. Most BASP sites are not MAT-certified, meaning we cannot administer daily or non-emergency medications (e.g., ADHD meds, insulin, Claritin, nasal spray).
   - All information must match the original pharmacy-labeled container, which must be provided to the site.
   - This form must be signed by both the parent/guardian and the child's health care provider.

Section 1: Allergies

If your child has *any allergies*, two (2) separate forms need to be completed. This includes severe, mild, or seasonal allergies. If your child will require an emergency medication (Epi-Pen, Auvi-Q, Benadryl) to be stored at site, there is a third form to be completed.

Form #1:
OCFS 6029 – Individual Allergy and Anaphylaxis Emergency Plan

Required For:

- Any child with a diagnosed allergy, including food, insects, environmental, medication, or seasonal.

What This Form Does:

- It tells staff what your child is allergic to, what symptoms to watch for, and exactly what to do in an emergency (including whether or not to give epinephrine).

Instructions for Each Section:

1. Child's Information

- Full legal name, DOB, and program name (e.g., "YMCA Bloomfield").

2. Allergy Type

- Be specific. Write "Peanuts," not "Nuts."
- Multiple allergies? List each one (e.g., Peanuts, Penicillin, Bee stings).

3. Reaction Risk

- Check how exposure might happen: ingestion, contact, airborne
  - Example: Airborne risk = sitting next to a peanut butter sandwich

4. Symptoms Checklist

- Check ALL symptoms the child has experienced or *could* have
  - If unsure, consult your doctor
  - Don't skip things like "shortness of breath" if the child has asthma.

5. Emergency Medication

- If your doctor checks the box saying, "Epinephrine should be administered", you **MUST**:
  - Submit a Medication Consent Form (OCFS-7002)
  - Supply the actual EpiPen or Auvi-Q for the program.
  - Without this, your child cannot attend.

6. Medication Storage Location

- "In locked medication box at YMCA site" is most common.
- If self-carrying (must be approved), write clearly: "Child will carry in backpack and will be trained."

7. Doctor Section

- Health Care Provider must sign and date.
- Parent/Guardian must also sign.

Form #2:
OCFS 7006 - Individual Health Care Plan for a Child with Special Health Care Needs

Required For:

- All allergies (even mild or seasonal)
- Asthma, ADHD, seizures, diabetes, ASD, hearing or mobility support
- Any chronic condition that requires staff to watch for symptoms or take action

What This Form Does:

- Outlines your child's condition and clear instructions for **what staff need to do daily or in an emergency**. Think of it as a manual for caring for your child safely.

Instructions for Each Section:

1. **Child Info & Condition Description:**
   - Use full name and DOB.
   - Describe the condition:
     - "Severe peanut allergy – airborne and ingestion risk."
     - "ADHD – takes medication at home, no intervention required at site."
2. **Description of Signs/Symptoms:**
   - List what staff should look for.
     - "Hives, coughing, red eyes, restlessness, disorientation."
3. **Daily Care Plan/Monitoring:**
   - Even if care is minimal, include it:
     - "Staff will remind child to take deep breaths if wheezing begins."
     - "No special action unless symptoms occur."
4. **Emergency Procedures:**
   - Use specific instructions like:
     - "Administer EpiPen if swelling or trouble breathing starts. Call 911 immediately. Then call parents."
5. **Staff Training Instructions:**
   - Usually: "Site Director and all counselors will be trained on use of EpiPen and recognizing signs of anaphylaxis."
6. **Medication Storage:**
   - "Locked medication box at site" or "Carried in backpack — staff aware and trained."
7. **Parent & Provider Signatures:**
   - Health Care Provider must sign and date.
   - Parent/Guardian must also sign.

Form #3
OCFS 7002 – Medication Consent Form (Complete as Needed)

Required For:

- Any child who will take a medication at the program (i.e. EpiPen, Auvi-Q, & Benadryl)

What This Form Does:

- Gives legal permission for YMCA staff to administer a specific medication under clearly outlined conditions.

Instructions for Each Section:

1. Child Info:

- Full legal name, DOB, program name.

2. Medication Info:

- ONE form per medication.
  - *Correct: "Benadryl 12.5mg/5ml"*
  - *Incorrect: "Benadryl + EpiPen" → Must be on separate forms.*

3. Route/Dosage/Frequency:

- Examples:
  - *"Oral – 5 ml – every 4 hours as needed for allergic reaction."*
  - *"Intramuscular – 0.15mg EpiPen – use immediately upon symptoms."*

4. Symptoms to Administer For:

- List clearly: "Hives, throat tightening, vomiting after exposure to nuts."
  - Do **not** write "as needed" without context.

5. Duration of Use:

- "September 2, 2025 – June 26, 2026"
  - OR: "While in attendance at YMCA"

6. Side Effects:

- "Sleepiness, dry mouth. If side effects worsen, notify parent."

7. Provider Signature + License #:

- Must be a doctor, NP, or PA

8. Parent Signature

- Must be the child's legal guardian.

Section 2: Asthma

If your child has asthma, even if it is mild or well-controlled, at least one (1) form must be completed. If your child will use an inhaler during program hours, two (2) forms are required.

Form #1:
OCFS 7006 - Individual Health Care Plan for a Child with Special Health Care Needs

Required For:

- All allergies (even mild or seasonal)
- Asthma, ADHD, seizures, diabetes, ASD, hearing or mobility support
- Any chronic condition that requires staff to watch for symptoms or take action

What This Form Does:

- Outlines your child's condition and clear instructions for **what staff need to do daily or in an emergency**. Think of it as a manual for caring for your child safely.

Instructions for Each Section:

1. Child Info & Condition Description:

- Use full name and DOB.
- Describe the condition:
  - "Severe peanut allergy – airborne and ingestion risk."
  - "ADHD – takes medication at home, no intervention required at site."

2. Description of Signs/Symptoms:

- List what staff should look for.
  - "Hives, coughing, red eyes, restlessness, disorientation."

3. Daily Care Plan/Monitoring:

- Even if care is minimal, include it:
  - "Staff will remind child to take deep breaths if wheezing begins."
  - "No special action unless symptoms occur."

4. Emergency Procedures:

- Use specific instructions like:
  - "Administer EpiPen if swelling or trouble breathing starts. Call 911 immediately. Then call parents."

5. Staff Training Instructions:

- Usually: "Site Director and all counselors will be trained on use of EpiPen and recognizing signs of anaphylaxis."

6. Parent & Provider Signatures:

- Health Care Provider must sign and date.
- Parent/Guardian must also sign.

Form #2
OCFS 7002 – Medication Consent Form (Complete as Needed)

Required For:

- Any child who will take a medication at the program (i.e. EpiPen, Auvi-Q, & Benadryl)

What This Form Does:

- Gives legal permission for YMCA staff to administer a specific medication under clearly outlined conditions.

Instructions for Each Section:

1. Child Info:

- Full legal name, DOB, program name.

2. Medication Info:

- ONE form per medication.
  - *Correct: "Benadryl 12.5mg/5ml"*
  - *Incorrect: "Benadryl + EpiPen" → Must be on separate forms.*

3. Route/Dosage/Frequency:

- Examples:
  - *"Oral – 5 ml – every 4 hours as needed for allergic reaction."*
  - *"Intramuscular – 0.15mg EpiPen – use immediately upon symptoms."*

4. Symptoms to Administer For:

- List clearly: "Hives, throat tightening, vomiting after exposure to nuts."
  - Do **not** write "as needed" without context.

5. Duration of Use:

- "September 2, 2025 – June 26, 2026"
  - OR: "While in attendance at YMCA"

6. Side Effects:

- "Sleepiness, dry mouth. If side effects worsen, notify parent."

7. Provider Signature + License #:

- Must be a doctor, NP, or PA

8. Parent Signature

- Must be the child's legal guardian.

Section 3: Other Medical Needs

If your child has a medical, behavioral, or developmental condition that may impact their experience in the program, you'll need to complete one (1) form. This applies even if the condition doesn't require medication and isn't allergy or asthma related.

These conditions might include ADHD, Seizures/Epilepsy, Anxiety, Diabetes, Autism Spectrum Disorder, or the use of medical devices like a glucose monitor or hearing aid. Even if your child hasn't experienced symptoms recently, staff still need to be aware of the condition and know what to look for, how to respond, and how to support your child day-to-day.

Form #1:
OCFS 7006 - Individual Health Care Plan for a Child with Special Health Care Needs

Required For:

- Any child with a medical, behavioral, or developmental condition that requires staff awareness, monitoring, or accommodation during program hours

What This Form Does:

- Explains your child's condition, outlines symptoms staff should watch for, and provides step-by-step instructions for how to support your child, both day-to-day and in the event of an emergency.

Instructions for Each Section:

1. **Child Info & Condition Description:**
   - Use full name and DOB.
   - Describe the condition:
     - "ADHD – impulsive behavior, may struggle with transitions, takes meds with school nurse before Y program"
2. **Description of Signs/Symptoms:**
   - List what staff should look for.
     - "Shaking or irritability when blood sugar drops."
3. **Daily Care Plan/Monitoring:**
   - Be specific about when staff should intervene and what they should do:
     - "Allow headphones during high-sensory activities."
4. **Emergency Procedures:**
   - Use specific instructions like:
     - "If child becomes disoriented or has a seizure, stay with child, call 911, and notify parent."
5. **Staff Training Instructions:**
   - "Staff will be trained to recognize signs of low blood sugar and notify parent immediately"
6. **Parent & Provider Signatures:**
   - Health Care Provider must sign and date.
   - Parent/Guardian must also sign.

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. **This includes minor or environmental allergies.**
- 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***)
Required: List any potentially anaphylactic allergies here. If epinephrine is checked below, you must provide an epinephrine auto-injector to the program, or your child will not be able to attend.		☐ 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)
Important: You may decide to remove low-risk allergies from this list or ask your child's physician to note on this form that you will not be providing epinephrine to the program for this allergy, even if there is a history of anaphylaxis.		☐ 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

The medication listed here must match the exact one you provide, in its original, labeled container.

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: **Most common: "Locked medication box at site"**

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: **Most common: "Locked medication box at site"**

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: _____

This section helps staff prevent accidental exposure. Your doctor may write something general like:

- **"Child does not share food"**
- **"Avoids all dairy-based snacks"**
- **"No outside food unless labeled allergy-safe"**

You can also add notes about lunch seating, hand washing, or anything unique to your child's care.

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:	☐ 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.

PLEASE COMPLETE THIS SECTION FULLY – DO NOT LEAVE BLANK
Include the name of the condition, a short description, and any specific needs. Be clear and detailed.

Examples:

- **"ADHD – Easily distracted. Struggles with group transitions. May require extra verbal reminders and check-ins from staff."**
- **"Autism Spectrum Disorder – May become overstimulated by loud noise. Needs frequent breaks and visual cues for transitions."**
- **"Seizure Disorder – Generalized seizures 1–2 times per year. Last occurred in March 2024. No known triggers. Staff should monitor for signs of disorientation or blank staring."**
- **Diabetes (Type 1) – Child monitors glucose levels independently with Dexcom. Needs access to snacks and water during outdoor play. Parent will be notified if levels are below 80."**

If your child has no daily symptoms but staff still need to be aware, write that here too.

- **"Has not had symptoms recently, but staff should be aware in case of future episode."**

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)

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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.

PLEASE COMPLETE THIS SECTION FULLY – DO NOT LEAVE BLANK
Use this space to explain what staff need to know, who will train them, and what to do in urgent situations.

Examples:

- **"Staff should be trained to recognize signs of low and high blood sugar. If symptoms occur, offer parent-provided juice or water, contact parent, and monitor. If symptoms worsen or child appears disoriented, call 911."**
- **"Parent and site director will train staff on seizure warning signs and response (e.g., timing, positioning, when to call 911)."**
- **"Staff will receive training on calming techniques and visual supports for child's sensory needs."**

Always include what staff should do if symptoms appear, when to call home, and when and how to escalate.

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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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 med
possible, measurable parameters): _____

8A. Possible side effects: ☐ See package insert for complete lis

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are r

☐ Contact parent ☐ Contact health care prov

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list

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

- **Always write the exact name and dosage of the medication as it appears on the prescription label.**
- **Clearly state when the medication should be given. *Staff cannot make this decision themselves. It must be written on the form.***
- **List specific symptoms for emergency medications like EpiPens, inhalers, or Benadryl.**
- **If there are situations when the medication should NOT be given, make sure they are clearly noted.**
- **Do not write "as needed," or "until further notice" anywhere on the form.**
- **All medication must be provided to the YMCA in its original labeled container, with a pharmacy label attached.**

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