Authorized Persons for Pick-Up

Child's Name: _____

Child's Date of Birth: _____

Center: _____

For safety reasons, BrightPath will only release a child to those individuals that have been designated by the child's parent(s) or legal guardian(s) as authorized to pick up the child. Legal counsel has informed us that unless a parent has secured an Order of Protection, both parents have equal rights to pick up the child. If an Order of Protection exists, BrightPath must be provided with an original copy of the Order. BrightPath must be informed of any individual(s) to whom the child **should not** be released.

The following person(s) are authorized to pick up my child:

	RELATIONSHIP	NAME	ADDRESS/PHONE
1.	Parent/Guardian		
2.	Parent/Guardian		
3.			
4.			
5.			
6.			
7.			
8.			

I understand that my child will only be released to the individuals I have listed above. I also understand that if my circumstances change, it is my responsibility to notify BrightPath and update the above list.

Parent Signature: _____

Date: _____

Door Code: _____

Approval of Policies

I have read, understand and agree to abide by the BrightPath policies, as put forth in the Parent Handbook and attached consent forms.

These policies include:

- Curriculum
- Hours/Sign-In Procedures
- Authorized Persons for Child Pick-Up
- Holiday/Snow Closings
- Absences
- Parent Involvement/Conferences
- Clothing Policy
- Electronics Policy
- Discipline Policy
- Field Trips
- Babysitting Policy
- Health Care Policies/Medical Release
- Prescription/Non-Prescription Medication Administration
- Nutrition and Food Allergy Policy
- Firearm Policy
- Child Abuse and/or Neglect Reporting
- Financial Policies/Agreement to Pay

_____ _____

Parent / Guardian Signature Date

_____ _____

Parent / Guardian Signature Date

Sleep/Rest Time Agreement

As an early care and education provider it is our responsibility to maintain a safe sleeping environment for your child. As per OCFS guidelines an agreement must be made outlining nap or rest time procedures for your child. **Please complete the form and return it to your Center Director. This agreement must be completed yearly.**
Thank You.

Sleep is an important part of healthy growth and development. When children sleep, their brains develop, they organize information, and they grow. Regular naps provide predictable routines and help children cope with the stimulating activities provided by the center.

Rest Schedule

Infants:

✓ In the infant rooms we provide opportunities for infants to nap as their individual schedule indicates. When infants are napping they are placed in an assigned crib and placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the center, by the parent that states this arrangement is inappropriate for that child.

✓ Infant cribs may not have bumper pads, toys, large stuffed animals, heavy blankets, pillows, wedges, or infant positioners unless medical information from the child's health care provider is presented in writing indicating otherwise. In lieu of blankets, EduKids requires that parents provide "sleep sacks" ONLY for their infant.

Toddlers\ Preschool: 2 Hour Timeframe as per Classroom Schedule – Typically 1:00 PM – 3:00 PM

✓ Children 18 months and older will nap on a cot in the classroom. Rest time occurs from 1:00 PM-3:00 PM. The room is darkened, soothing music is played and backs will be rubbed if the child wishes. No child is ever forced to sleep, however, this is a quiet time and children are asked to rest quietly for a short time until those children needing to nap have settled. For those children who do not nap, they will be offered quiet activities; remembering that other children are sleeping.

✓ As children wake they will be allowed the same quiet activities. The staff will wake up all children with back rubbing, soft voices and kindness around 3:00 PM. Blankets will be put back in the child's cubby and children will be offered snack.

UPK Wrap Around Care: 2:00 PM - 3:00 PM (At select locations only)

✓ The UPK Extended Day/ Wrap Around children will be given the opportunity to nap from 2:00 PM-3:00 PM with the same rest time arrangement as our center children as stated above.

Supervision During Rest Time

As per the requirements specified in section 418-1.8 of the NYS OCFS Regulations, all children will have competent supervision by classroom staff during rest times. Children will be within a staff members range of vision, and will be close enough to assist a child who wakes from nap, or is playing quietly in the classroom. Please sign below indicating your understanding and agreement. If you have questions about this agreement or questions about your child's individual needs, please discuss this with the Center Director.

_____ _____

Parent Signature Date

_____ _____

Child's Name Classroom

Connect (Parent Engagement Program)

I _____ (Parent/Guardian Name) am the parent or guardian of _____ (Child's Name) (the "**child**") and have voluntarily chosen to participate in Connect (the "**Engagement Program**").

Participation Agreement

In consideration for BrightPath, its subsidiaries and affiliates (together "**BrightPath**") providing Connect (Engagement Program), accepting my application to participate in Connect Engagement Program, and providing me access to Connect (Engagement Program), I hereby understand, acknowledge, and agree that:

(a) Our participation in Connect (Engagement Program) is entirely voluntary and undertaken at my own and my child's risk.

(b) I have read the Connect Parent Engagement Information Letter attached hereto and I had all my questions in relation to Connect Engagement Program answered to my satisfaction prior to deciding to sign this Participation Agreement.

(d) I understand that I am prohibited from sharing photos and/or video of any children (other than my child), including any group photos/video, that I may have access to through my participation in the Connect Engagement Program. Should any photos and/or videos of children other than my child be distributed in violation of this covenant, I agree to indemnify and hold harmless BrightPath and its agents, employee, affiliates and/or assigns for all claims, liabilities, damages, losses and expenses (including legal fees on a solicitor and own client full indemnity basis) arising by reason of my unauthorized distribution in breach of this covenant.

(e) I understand and acknowledge that the Connect Engagement Program relies on the use of a third party provider (the "**Developer**") that utilizes the internet and cloud computing technology. Accordingly I acknowledge that the Developer will have access to information, photos and videos of and about my child and may create and hold electronic copies of this information for the purposes of back-up. The Developer may also monitor, for its internal use only, my access and use of the Connect Engagement Program. I understand and acknowledge that there are inherent privacy and confidentiality risks when using an internet-based service and cloud computing technology upon which the Connect Engagement Program relies. I understand and accept that BrightPath will have no liability in the event of any breach of confidentiality of any information collected and copied from the Connect

Engagement Program, whether or not such breach resulted from the actions of the Developer of BrightPath, its agents, employees, or assigns, or of any other parents who also participate in the Engagement Program. My participation in and use of the Connect Engagement Program is an acceptance of this limitation of liability.

(f) For greater certainly, I hereby release and forever discharge and agree not to make any claim against BrightPath, its board of directors, officers, agents, employees, affiliates and/or or assigns, for any and all claims, resulting from my participation and my child's participation in the Connect Engagement Program; and

(g) I understand and acknowledge that the terms of this waiver shall apply equally to me, and to my child.

Approval for Photos/Videos

I hereby grant permission to BrightPath and its representatives to photograph and video my child, and otherwise capture my child's image and to make recordings of my child's voice for the purposes of sharing information about my child with me under the Connect Parent Engagement Program.

I further grant permission to BrightPath and its representatives to reproduce, use, exhibit, display, post or distribute any images and recordings of my child when such images or recordings are taken in a group, or in a multiple child setting, to other parents who are also participating in the Connect Parent Engagement Program.

I hereby confirm and covenant that I will not share photos of any child (including group photos), other than my own, that I receive through the Connect Parent Engagement Program with anyone other than BrightPath and its employees.

I hereby release, defend, indemnify and hold harmless BrigthPath, employees or agents from and against any claims, damages or liability arising from or related to the use of images, recording or materials of my child, whether individually or in a group setting.

_____

(Name of Child)

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Witness) (Date)

Primary email: _____

Dear BrightPath Parent,

We are pleased to inform you of our Parent Engagement Tool (Connect). Connect is a technological tool that will keep you up-to-date of your child's day and facilitate even greater communication between your family and the BrightPath Centre.

Through parent surveys and continuous communication with families, we have been informed that parents want to learn more about their children and what activities the children have been doing while at the Centre.

Connect is a developed application, through which you'll receive real-time email updates and access to a complete history of your child's experience in our Centre through a smartphone or desktop computer.

What is Connect?

Connect will be used by our teachers to record activities on their tablets as they happen throughout the day to keep you informed on everything from nutritional information to fun moments and learning activities.

Photos and videos are stored safely and securely in a journal format that you can access from home or through the mobile app.

What does this mean for me?

Through Connect, you will be kept informed by receiving digital updates on your child to complement our important face-to-face interactions. The daily reports include meal, nap, toilet, mood, supplies and activity updates. Families can expect two photos a week with activity descriptions and skill development indicators. It's also a great way to reinforce your child's in-program learning when you are at home, as you'll have timely insight into what they've been working on throughout the day.

You will receive an email with login credentials to your account once the *photo waiver* has been signed and submitted. Your access to the program will begin upon your child's start date with BrightPath.

We know this tool is a great asset to our families and we appreciate your feedback, as well as your support.

Sincerely,

BrightPath Management

Developmental History

Child's name:_____ Birth Date:_____

Who resides with your child in the home, in addition to his/her parents?

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

Name:_____ Relationship:_____ Birthdate:_____

What is the primary language spoken in your home? _____

Personal History (Check all that apply)

Crawls☐ Walks☐ Talks☐ Speaks in Sentences☐

Special conditions or allergies?

Social History (Please check all that apply)

Plays well with others?☐ Prefers playing alone?☐ Naturally friendly?☐

Aggressive?☐ Shy?☐

What group contacts has your child had with other children?

Has your child ever attended any other child care program? Yes

If yes, please explain why you left:

What activities does your child particularly enjoy?

Fears: Animals?☐ Dark?☐ Storms?☐ Strangers?☐

Noise?☐ Others?_____

How do you comfort your child?

Self Help (Check all that apply)

Toileting habits Diapers? ☐ Pull ups? ☐ Training? ☐

Trained? ☐ Adult assistance needed? ☐ Cleans self? ☐

Frequent accidents? ☐ Occasional accidents? ☐

Special bathroom words? _____

Sleeping habits Blanket? ☐ Thumb? ☐ Animal? ☐

Pacifier? ☐ Bedtime _____ AM Wake time _____

How does your child sleep best? _____

Favorite foods? _____

Refused foods? _____

Special diet? _____

Does your child have any allergies, asthma, insect allergies, frequent ear infections, eye problems?

Does your child dress him/herself? _____

Indoor clothes? _____ Outdoor clothes? _____

Does child have any pets? _____ If so, please give name(s):

How is child disciplined at home?

What helps when your child is upset?

Do you have information that would help us better care for your child?

Please describe by approximate time, your child's current daily activities including nap and meal times?

Signature _____ **Date** _____

Parent or Guardian

Developmental History - Infant Supplement

Child's Name:

Birth Date: Birth Weight:

Birth Place: Current Weight:

Were there complications during pregnancy or at birth? Yes

If yes, please describe:

Did you bring your baby home from the hospital with you? Yes

If not, please briefly describe why:

Is your infant nursing, formula fed or supplemented with bottles? Nursing

Name of Formula used:

Please clearly describe feedings:

Feeding Schedule - Please indicate exact amounts of formula/breast milk needed at each feeding along with any cereal or baby food/table food:

Please describe in detail your infants "rhythms" of the day including awake times, "fussy" periods, naps and rest periods, play times and how often you typically stimulate your baby through toys and music.

Does your child...

Sleep through the night:

Self sooth:

Settle when held, worn in a sling/baby carrier, etc:

Turn their head:

Sit in a bouncy seat:

Burp after feedings:

Use a pacifier:

Suck their thumb:

Sit in a swing:

Engage in/Enjoy tummy time:

Who does your child live with? Please list the names of all persons living in your household. Be sure to include the names and ages of all siblings:

Does your child have any allergies or suspected allergies? If yes, please describe in detail:

What else would you like us to know about your little one or your family?:

We encourage parents to try new foods with children at home before we introduce them at BrightPath in case of allergies or food sensitivities. Once children have moved to table food, consistently, parents will be provided with our rotating menu from their center. If your child is currently on table food, please circle and date the items (on the menu) that you give permission to serve to your child for lunch as well as for AM/PM snack.

Infant Feeding Agreement

As an early care and education provider, it is our responsibility to maintain a safe classroom environment for your child. As per OCFS guidelines, an agreement must be made outlining feeding procedures for your child. Please review the following statements, sign, and return it to your Center Director.

- A schedule of your child's feeding/drinking routine must be provided by the family and updated as needed including times and types of fluids/foods offered. Template attached.
- All containers or bottles of breast milk, formula or other individualized food items must be provided by family and clearly marked with the child's complete name.
- Bottles should be prepared and provided by the family each day. Designated staff members may prepare formula when agreed to in writing by the parent.
- Unused portions of bottles or containers from which children have eaten must be discarded after each feeding or placed in a securely tied bag and returned to parent at the end of the day. Please let us know your preference.
- Bottles and food items will be warmed using hot water. Microwave use is prohibited.
- Every effort will be made to accommodate the needs of a child who is being breast fed. If you wish to visit the center to breast feed, please let your Center Director know so that private space is made available.
- Infants six months of age or younger will be held while being bottle fed. Infants older than six months will be held until the infant consistently demonstrates the capability of holding the bottle and ingesting an adequate portion of the contents. At that point, infants may sit in a highchair with their bottle.
- Age-appropriate solid foods will be introduced in consultation with families.
- Current menus for each week will be available on parent boards as well as in the parent communication app.

Please sign below indicating your understanding and agreement. If you have questions about this agreement or questions about your child's individual needs, please discuss this with the Center Director.

_____ _____

Parent Signature Date

_____ _____

Child's Name Classroom

Infant Feeding Schedule

Child's Name: Date of Birth:

Fluids

Please select type of fluids:

☐ Breast Milk ☐ Formula (brand:) ☐ Milk

Initial here to give staff permission to prepare bottles: _____

Please list times and amount for bottles to be given:

Foods

Please list times, types, and amounts of solids to be given (jar food, baby cereal, finger foods, etc.):

Allergies and Special Instructions

Please list any known allergies, food intolerances, restrictions or special instructions regarding your child's eating habits:

Parent signature _____ Date _____

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT 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. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label 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 _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law):

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Faciity ID number:	17. Program telephone number:
BrightPath		

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:
Cindy Del Valle	

21. Staff's signature:

X

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

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: / /

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