REACH Community & Youth Agency, Inc.
Providing social, recreation, education, informational and advocacy programs for youth and families of Half Hollow Hills and Commack since 1972.
525 Half Hollow Road, Dix Hills, NY 11746 631-549-9417 fax 631-549-1272 www.reachcya.org email: info@reachcya.org

WRITTEN MEDICATION CONSENT FORM

(Need 1 form for each Medication)

NO Before/Afterschool application will be accepted unless the following forms have been completed and medication has been given.

- **Written Medication Consent form: *OCFS form #7002***
  sections #1-#18 completed by Physician. Section #4 must reflect the Medication name and strength (ex: Epinephrine Epi-Pen 0.15mg) and for Diphenhydramine (ex: Children's Benadryl 12.5 mg). These forms must be stamped, signed and dated. (fax copy is acceptable)

- **Written Medication Consent *OCFS form #7002***
  sections #19-#23 completed by Parents.

- **Individual Health Care Plan: *OCFS FORM# 7006***
  Parts A & B *completed by parent in collaboration with information given by the child's Healthcare Provider*. PARENT MUST SIGN ON PAGE 2
  (1 FORM FOR EACH ALLERGY IF TRIGGERS/SYMPTOMS ARE DIFFERENT)

- **Epinephrine (ex: Epi-pen, Epi-Pen Jr, Auvi-Q, Impax Epinephrine, Mylan Epinephrine) and Diphenhydramine (Benadryl/Generic brand), Inhaler medication, Nebulizer medication must be in its original box with legible expiration dates with the Pharmacy label (with child's name) affixed to medication.**

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.
- This form or an approved equivalent may be used when written consent to administer medication to a child is required from both the Licensed Authorized Prescriber and the Parent.

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

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 prescriber 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 situations 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 require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ 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?

☐ No ☐ 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 *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*:
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

X

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WRITTEN MEDICATION CONSENT FORM

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

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

20. I, the parent, authorize the day care program to administer the medication as specified herein.

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 name:	25. license/registration 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. Child care provider's name (please print):	29. Date received from parent:

30. 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, 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 - #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 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.

36. Licensed Authorized Prescriber's Signature:
X

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34. Licensed Authorized Prescriber's Signature:
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36. Licensed Authorized Prescriber's Signature:
X

NEW YORK STATE
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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: Part A:

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. Part B:

Allergy:
Triggers:
Symptoms(mild reaction)to look for:
Procedure for handling mild symptoms:
Symptoms(Severe reaction)to look for:
Procedures for handling severe symptoms:

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.

Approved CPR-1st Aid training Staff: Only those on the previous page may administer emergency medication.

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: 631-549-9417
Child care provider's name (please print): JILL LUBECK - DIRECTOR		Date:
Child care provider's signature: X		

Signature of Parent:

X	Date:

Child's Name:_____ School:_____ Date:_____

AFTER SCHOOL- SNACKS:

- Animal Crackers-Austin (PreK)
- Baked potato Crisp-Lays
- Baked Sour Cream Crisps-Lays
- Cheetos Puffs Whole Grain Reduced Fat-Frito Lay
- Cheezit-Reduced Fat
- Chips Ahoy 100 calorie pack-Nabisco
- Cool Ranch Doritos-Reduced Fat
- Fruit Snacks Mixed Berry-Kellogg (kept on site for gluten free circumstances)
- Goldfish 100 calorie pack-Pepperidge Farm
- Goldfish Bulk-Pepperidge Farm (PreK)
- Goldfish Whole Grain Pretzel-Pepperidge Farm
- Graham Crackers-Nabisco
- Nacho Doritos-Reduced Fat
- Oreos 100 calorie pack-Nabisco
- Popcorn Cheddar-Smartfood
- Tiny Twists Pretzels-Rold Gold
- Vanilla Wafers-Keebler (PreK)

BEFORE SCHOOL- CEREALS:

- Apple Jacks-Reduced Sugar
- Cheerios
- Cinnamon Toast Crunch-Reduced Sugar
- Cocoa Krispies
- Frosted Flakes-Reduced Sugar
- Frosted Mini Wheats
- Fruit Loops-Reduced Sugar
- Kix
- Trix-Reduced Sugar

BEFORE SCHOOL- NUTRIGRAIN WHOLE GRAIN BARS and DISTRICT BAGELS:

- Apple-Kellogg
- Strawberry-Kellogg
- Blueberry-Kellogg
- School Bagel
- Cream Cheese
- Butter

I have checked off all items my child *MAY HAVE* in the before/after school programs.

_____ _____

Parent Name (please print) Parent Signature