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.

DIAGNOSIS:	ALLERGY:
HOW TO AVOID EXPOSURE TO ALLERGEN:	
SYMPTOMS TO LOOK FOR:	WHAT TO DO:
	( ) Follow FARE Allergy & Anaphylaxis Plan
	( ) Give Epinephrine as ordered
	( ) Give Benadryl as ordered
	( ) Follow Asthma Action Plan
	( ) Give Asthma inhaler/nebulizer as ordered
	( ) Other:
	WHO TO CALL:
	( ) 911 immediately
	( ) 911 after administering Epinephrine
	( ) 911 if breathing difficulty persists after using Asthma inhaler or nebulizer
	( ) Parent/Guardian ( ) Notify OCFS
WHAT TO DO IF TREATMENT FAILS:	

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)
	Site Supervisor
	Site Director

IS THE MEDICATION CONSENT FORM SIGNED, IF APPLICABLE? Yes No

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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.

HOW IS STAFF TRAINED TO RESPOND TO THE CHILD'S NEEDS?			
Staff is certified in child CPR AND FIRST AID	Yes	No	NA
Staff knows how to recognize and treat anaphylaxis	Yes	No	NA
Staff knows how to use a nebulizer and/or an asthma inhaler	Yes	No	NA
Staff knows how to administer an Epinephrine Auto-injector	Yes	No	NA
Staff knows how to administer oral Diphenhydramine	Yes	No	NA

STAFF NEEDS TO BE TRAINED IN:
Training will be provided by: ( ) Parent/Guardian ( ) Health Care Provider ( ) Health Care Consultant

IS THE CHILD ALLOWED TO CARRY THE MEDICATION?	Yes	No
IS THE CHILD ABLE TO USE THE MEDICATION DEVICE INDEPENDENTLY?	Yes	No

If child refuses or is unable to self-treat, a trained adult must give the medication.

DOES THE CHILD NEED SUPERVISION/ASSISTANCE WITH THE DEVICE?	Yes	No

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/Guardian

X	DATE: / /