Alternatives For Children
Health and Safety Related Policies and Procedures
Allergies/Anaphylaxis Policy
2021.11.30

Allergies/Anaphylaxis Policy

Alternatives For Children maintains a safe environment for children and delivers services in a setting that meets all applicable health and safety codes and physical plant standards.

AFC obtains specific allergy information related to each child and has preventative and responsive policies and procedures in place. All children with allergies are identified and a specific treatment plan is developed to meet the unique needs of each child.

Upon entering the program, Alternatives For Children obtains the necessary allergy information and documentation required.

The parent is required to complete the following before services are delivered:

- Emergency Contact and Emergency Room Release Form which alerts AFC that the child has an allergy.

The child's physician is required to complete the following:

- Health Examination Form which alerts AFC to a child's allergy.
- Medication Consent Form [OCFS – LDSS – 7002 (5/2015) {S}] specifying the name of the medication, dosage, frequency, and circumstances in which medication is to be given.
- Any child with a severe allergy at risk for anaphylaxis must have and Individual Allergy and Anaphylaxis Emergency Plan [OCFS-6029 (01/2021) {S}] completed in collaboration with the school nurse, child's parents and child's doctor.

The Health Care Consultant works with the child's parents and physician to complete Individual Health Care Plan [OCFS-LDSS-7006 (5/2014) {S}]

Attachment 1 - Health Examination Form

Attachment 2 - Emergency Contact and Emergency Room Release Form

Attachment 3 - Medication Consent Form [OCFS – LDSS – 7002 (5/2015) {S}]

Attachment 4 - Individual Health Care Plan for a Child With Special Health Care Needs [OCFS-LDSS-7006 (5/2014) {S}]

Attachment 5 - Individual Allergy and Anaphylaxis Emergency Plan [OCFS-6029 (01/2021) {S}] This plan will provide a detailed description of a student's allergies, doctor's orders and contact information and parent's emergency information. It is kept in the nurse's office.

Preventative Measures

The following measures are taken to prevent a child from exposure

Step	**Action**
1	AFC is a nut free environment. • AFC provides nutritional snacks that are nut free. • Home baked goods are not permitted in the classrooms. • List of approved peanut free "snacks" are given to parents. • Food items brought from home must be cleared before entering the classroom (ingredients as well as manufacturing information are checked on packaged foods).
2	Hand washing: • Staff and Children's hands are washed upon entering and re-entering the classroom, before and after playground time, at snack and project time. • All staff that have contact with children must wash hands prior to treatment or use germicidal wipes. • All staff who have contact with children must refrain from ingesting peanut related products. • All surfaces must be thoroughly wiped down before the child engages in service/activity.
3	Notification - Allergy information is posted to prevent exposure: • A general allergy notice is posted inside the classroom at (at point of entry) and updated as needed. • Child specific allergy information is posted in the classroom (lists what the child CANNOT have or be exposed to). • The child's Individual Allergy and Anaphylaxis Emergency Treatment Plan and Medication Consent Form are located in the nurse's office, the child's file in the main office, and digitally on content central. • All supervisors and members of the child's treatment team must be aware of the child's allergy, manifestations and protocol of treatment.

- Allergy information is also included in the substitute teacher packet and the substitute nurse's packet.
- Teaching staff will notify covering substitutes of any allergies and Individual Health Care Plans for a Child with Special Needs.
- Allergy and Anaphylaxis Emergency Plan will be updated annually and posted on school web site.

4	Staff Training • All new and existing staff as well as substitutes will complete a staff orientation upon hire and yearly which includes health care policies, allergy, epi-pen training and infection control. • Nurse meets with all new staff individually to review handwashing procedures, gloving techniques, train on epi-pen use and allergy safety. Also included at onboarding in the Universal Precautions/BSI Guidelines Health Care Plan Training. • During student team meetings the team will discuss each individual child's health plan and allergy and anaphylaxis plan.

Allergic Reaction Procedure

If a child experiences an allergic reaction, the following steps are taken:

Step	**Action**
1	The teacher/therapist contacts the school nurse.
2	The nurse reviews the child's specific Individual Health Care Plans for a Child with Special Needs.
3	The nurse attends to the child and administers medication where applicable (as documented on the Individual Allergy and Anaphylaxis Emergency Treatment Plan and Medication Consent Form).
4	School administrator or school nurse calls the parent to advise them of the child's condition and continues to keep the parent informed as to the child's status.
5	If the child's condition worsens and/or if epinephrine is given, EMS is immediately contacted. The parent is also contacted.
Note	If EMS is contacted, an incident report is filed. Classroom staff will complete a child Incident Report [OCFS - LDSS - 4436 {S}] and school administrator will notify OCFS. **Attachment 6** - Incident Report for Child Day Care [OCFS - LDSS - 4436 {S}]

Snacks and Lunch

Snacks are provided by AFC. Parents may elect to send their child in with a snack or drink, so long as it is Nut Free. If the child attends school for more than 3 hours a day, the parent's must provide the lunch/drink.

NOTE

AFC is not permitted to heat a child's food in the microwave. If the parent elects to send a child in with a hot meal, it must be heated at home and sent to school in a thermos.

If the child is participating in a special feeding program, the child's therapist may request particular foods.

Red Emergency Backpack

Contents

The **Red Emergency Backpack (REB),** is a backpack equipped with the following:

- gloves
- tissues
- First Aid kit
- Name-to-Face logs
- emergency contact information

Individual student EPI-PENs are stored in the front pocket of the REB. The prescription/medical order accompanies the EPI-PEN in the REB.

Storage & Use

There is an equipped REB in every classroom.

The REB is inaccessible to all children in the classroom.

If the REB contains an EPI-PEN, it is kept in a cool, dry area of the classroom. When outdoors, it is kept in a shaded area to the best extent possible.

Staff are required to take the REB, the walkie-talkie, a cellphone, or other form of communication with them anytime they leave the building with one or more students.

When evacuating the building, teachers/therapists will carry their cellphones with them.

EPI-PEN

Administration (Education Law 902-a, b 916-a, b 921)	For treatment of students with diabetes or allergies, duly licensed nurses, nurse practitioners, physician assistants and physicians are authorized to administer a prescribed epinephrine auto-injector, calculate prescribed insulin dosages, administer prescribed insulin, program the prescribed insulin pump, refill the reservoir of the insulin pump, change the infusion site, inject prescribed insulin, teach an unlicensed person to administer glucagon to an individual, and perform other authorized services pursuant to their scope of practice to students who have both a provider order and written parent/guardian consent for such.
Training	School districts, BOCES, and nonpublic schools are authorized, but not obligated to have, licensed registered nurses, nurse practitioners, physician assistants, and physicians to train unlicensed school personnel to inject prescribed glucagon or epinephrine auto-injectors in emergency situations, where an appropriate licensed health professional is not available, to students with a provider order and written parent/guardian consent. Unlicensed school personnel employed by school districts, BOCES and nonpublic schools must complete an annual training course regarding the administration of prescribed epinephrine auto-injectors to a student. Such training must be provided and documented by an authorized licensed health professional. A licensed health professional employed by AFC will provide training to all existing and new staff on an ongoing basis according to regulation and specific need. Components of such training shall include but not be limited to: (1) identification of the specific allergen(s) of the student(s) with a review of each student's emergency health plan with the child's individual team, if applicable; (2) signs and symptoms of a severe allergic reaction warranting administration of epinephrine; (3) how to access emergency services per school policy; (4) the steps for administering the prescribed epinephrine auto- injector; (5) observation of the trainee using an epinephrine auto-injector training device; (6) steps for providing ongoing care while waiting for emergency services; (7) notification of appropriate school personnel; (8) methods of safely storing, handling, and disposing of epinephrine auto-injectors.
Availability/ Access 136.7(13)(3)(i) 136.7(13)(3)(ii)	AFC is not required to retain, or make available at all times, a licensed nurse, nurse practitioner, physician assistant or physician for the sole purpose of taking custody of any epinephrine auto-injector.

An epinephrine auto-injector provided by the parent/guardian must be made available to the student as needed in accordance with school policy and the orders described by the duly authorized health care provider.

AFC treating staff are required to have a student's EPI-PEN with the student throughout the day. This includes all transitions and related service treatments. The treating clinician is required to have the EPI-PEN for the duration of the session, ensuring it is inaccessible to all children. Upon return to the classroom, the clinician signs the Name-to-Face log, checking the box indicating the return of the EPI-PEN to the classroom with the child. The EPI-PEN is available throughout the school day, on school property and at any school function, including off-site events.

Storage

The student's EPI-PEN will be stored in the red emergency backpack in the child's classroom. The EPI-PEN travels with the student at all times, and any time the class leaves the room. The EPI-PEN is inaccessible to all children at all times.

Definitions 136.7(2)
136.7(11)
136.7(12)
136.7(13)

Epinephrine auto-injector means an automated injection delivery device, approved by the United States Food and Drug Administration, for injecting a measured dose of the drug epinephrine.

Duly authorized health care provider means a licensed health professional who is authorized to diagnose medical conditions and prescribe medications and treatments in accordance with his/her respective scope of practice, including but not limited to a physician, physician assistant, and nurse practitioner.

School day means any day, including a partial day that students are in attendance at school or facility for instructional purposes.

School property means in or within any building, structure, athletic playing field, playground, parking lot or land contained within the real property boundary line of a school or facility for instructional purposes, or in or on a school bus.

Note

The bus company is contracted through the county. AFC is not responsible for bussing policy and procedures.

School function means a school sponsored extra-curricular event or activity regardless of where such event or activity takes place, including but not limited to an event or activity that may take place in another state.

AFC meets the definition criteria as follows:

- AFC is a 4410 preschool provider operating four (4) facilities.
- AFC is responsible for all four (4) of its facilities and school properties.
- The municipalities via contract are responsible for transportation via a school bus.
- AFC is responsible for all of its school functions.
- AFC utilizes licensed, registered professional nurses.

Attachment 1	Health Examination Form
Attachment 2	Emergency Contact and Emergency Room Release form
Attachment 3	Medication Consent Form [OCFS – LDSS – 7002 (5/2015) {S}]
Attachment 4	Individual Health Care Plan for a Child With Special Health Care Needs [OCFS-LDSS-7006 (5/2014) {S}]
Attachment 5	Individual Allergy and Anaphylaxis Emergency Plan [OCFS-6029 (01/2021) {S}] This plan will provide a detailed description of a student's allergies, doctor's orders and contact information and parent's emergency information. It is kept in the nurse's office,
Attachment 6	Incident Report for Child Day Care [OCFS - LDSS - 4436 {S}]

ATTACHMENT 1

Alternatives for Children

Aquebogue 631-722-2170 Fax 631-722-2177 • East Setauket 631-331-6400 Fax 631-331-6865
Dix Hills 631-271-0777 Fax 631-271-0999 • Southampton 631-283-3272 Fax 631-283-3356

REQUIRED HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School: **Alternatives for Children**		Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	Type: ☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

The school will develop an individual Health Care Plan for the student in accordance with physician instruction, where applicable.

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/PLAYGROUND

☐ **Student is free from contagious and communicable disease and is able to participate in daycare/preschool**

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in (specify):**

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, etc.)
Use additional space below to explain.

Summary of Physical Exam:

MEDICATIONS

☐ Order Form for Medication(s) Needed at School Attached

IMMUNIZATIONS

☐ Record Attached

HEALTH CARE PROVIDER

Medical Provider Signature:	
Provider Name: *(please print)*	*License #:*
Provider Address:	
Phone: Fax:	

Please Return This Form To Your Child's School When Completed.

ATTACHMENT 2

ALTERNATIVES FOR CHILDREN

East Setauket – 631-331-6400 ● Southampton – 631-283-3272 ● Aquebogue – 631-722-2170 ● Dix Hills – 631-271-0777

EMERGENCY CONTACT AND EMERGENCY ROOM RELEASE FORM
SCHOOL YEAR 2021-2022

Child's Last Name _____ **Child's First Name** _____ **Date of Birth** _____
mm/dd/yyyy

Mother's Name:_____ Father's Name: _____
Address: _____ Address: _____
_____ _____
Home Telephone: _____ Home Telephone: _____
Cellular Number: _____ Cellular Number: _____
E-mail Address: _____ E-mail Address: _____
Guardian Name (if applicable) _____ Telephone#_____
Parent's Place of Employment: Father _____ Telephone# _____
Mother _____ Telephone# _____

Stay-At-Home-Parent (please check) [ ] Mother [ ] Father

School District: _____

If the school cannot contact either parent, please name two local friends/relatives who may be called upon to assume responsibility if your child is ill or injured. ****YOU *MUST* COMPLETE THIS SECTION****

Name: _____ Relationship: _____
Address: _____
Home Telephone: _____ Cellular Number: _____

Name: _____Relationship: _____
Address: _____
Home Telephone: _____ Cellular Number: _____

Local Physician (to be called in an emergency) _____ Telephone Number: _____
Local Dentist (to be called in an emergency) _____ Telephone Number: _____

Transportation of an ill or injured child is to be arranged by parent or person named above. ***(It is the parent(s)' responsibility to notify the school in writing of changes in the above).***

Please list illness, accident or injury that your child has had in the past year---please include date of occurrence. _____
_____

List medications currently being taken and circle if taken at home or in school. If prescription medication is to be given at school, a prescription is needed from the physician indicating how our school nurse is to administer it. If non-prescription medication is to be administered, a note from the parent must be submitted.

Name of Medication	Times Per Day	Dose	Circle if taken at home or in school	
			Home	School
			Home	School
			Home	School

Allergies to Food: _____
Specific Dietary Restrictions:_____
Allergies to Medicine: _____

Medical Condition/Diagnosis: None____ Diabetes ____ Heart Disease ____ Autism ____ Seizure Disorder____ Cerebral Palsy ____ Down Syndrome ____ Convulsions____ (date of incidents this year)_____
Any other medical diagnosis or medical condition _____

Special Traveling Equipment Needs: Wheelchair ____ Car Seat ____ Seat Belt ____ Braces ___ (Type) _____
Other _____

In the event of emergency medical treatment during school hours:
____ **I DO** ____ **I DO NOT** give permission for my child to be treated in the nearest Emergency Room.

In case of laceration requiring stitches:
_____ I DO ____ **I DO NOT** give my permission to have this done in the Emergency Room.

PARENT SIGNATURE _____ DATE _____

ALTERNATIVES FOR CHILDREN

East Setauket – 631-331-6400 ● Southampton – 631-283-3272 ● Aquebogue – 631-722-2170 ● Dix Hills – 631-271-0777

FORMULARIO DE CONTACTO DE EMERGENCIA Y DE LIBERACIÓN DE SALA DE EMERGENCIA
Año Escolar 2021 – 2022

Apellido del niño _____ **Nombre del niño** _____ **Fecha de nacimiento** _____
mes/día/año

Nombre de la madre: _____ Nombre del padre: _____
Dirección: _____ Dirección: _____
_____ _____
Teléfono del hogar: _____ Teléfono del hogar: _____
Número del celular: _____ Número del celular: _____
Dirección de E-mail: _____ Dirección de E-mail: _____
Nombre del tutor (si es el caso) _____ Nro. de Teléfono _____
Lugar de empleo del padre: Padre _____ Nro. de Teléfono _____
Madre _____ Nro. de Teléfono _____
Padre que permanece en la casa (verifique) [ ] Madre [ ] Padre

Distrito escolar: _____

Si la escuela no puede contactar cualquiera de los padres, nombre dos amigos o parientes que puedan ser llamados para asumir la responsabilidad si su niño se enferma o sufre una herida. ****USTED *DEBE* COMPLETAR ESTA SECCIÓN****

Nombre: _____ Relación: _____
Dirección: _____
Teléfono del hogar: _____ Número del celular: _____

Nombre: _____ Relación: _____
Dirección: _____
Teléfono del hogar: _____ Número del celular: _____

Médico Local (para llamarlo en una emergencia) _____ Número de teléfono: _____
Dentista Local (para llamarlo en una emergencia) _____ Número de teléfono: _____

El transporte de un niño enfermo o herido será organizado por el padre o la persona nombrada arriba. ***(Es responsabilidad del padre notificar a la escuela por escrito cualquier cambio en los datos arriba mencionados).***

Liste las enfermedades, accidentes o heridas que su niño ha sufrido el año pasado--- incluya la fecha de ocurrencia. _____
_____

Liste los medicamentos que toma actualmente y si los toma en el hogar o en la escuela. Si la prescripción debe administrarse en la escuela, se necesita una prescripción del médico que indique como debe administrarla nuestra enfermera de la escuela. Si se debe administrar un medicamento de venta libre sin receta médica, será necesaria una nota del padre.

Nombre del medicamento	Veces al día	Dosis	Haga un círculo si los toma en el hogar o en la escuela.
			Hogar Escuela
			Hogar Escuela
			Hogar Escuela

Alergias a comidas: _____
Meriendas de dieta especial: _____
Alergias a Medicinas: _____

Afección médica/Diagnóstico: Ninguna _____ Diabetes _____ Enfermedad cardíaca _____ Autismo _____ Trastorno convulsivo _____
Parálisis cerebral _____ Síndrome de Down _____ Convulsiones (fecha de los incidentes este año) _____
Cualquier otro diagnóstico médico o afección médica _____

Necesidades de equipos de viaje especiales: Silla de ruedas ____ Silla infantil ____ Cinturón de seguridad ____ Aparatos ortopédicos ____ (Tipo) _____ Otros _____

En el caso de tratamiento médico de emergencia durante horas de escuela:
_____ **DOY** _____ **NO DOY** permiso para que mi niño sea tratado en la Sala de Emergencia más próxima.

En caso de heridas que necesiten suturas:
_____ **DOY** _____ **NO DOY** permiso para que mi niño se le haga esto en la Sala de Emergencia.

FIRMA DEL PADRE _____ FECHA _____

ATTACHMENT 3

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

ATTACHMENT 4

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.

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.

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: **X**		

Signature of Parent:

X	Date:

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

PLAN INDIVIDUAL DE ATENCIÓN MÉDICA PARA UN NIÑO(A) CON NECESIDADES ESPECIALES DE SALUD

Usted puede usar este formulario o un documento equivalente aprobado de un plan individual de atención médica desarrollado para un niño(a) con necesidades especiales de salud.

Un niño(a) con necesidades especiales de salud se refiere a un niño(a) que tiene una condición física crónica, de desarrollo, conductual o emocional que se espera que dure 12 meses o más y que requiere servicios de salud y otros relacionados a la salud de un tipo o en una magnitud que excede la requerida por otros niños en general.

Trabajando en colaboración con el padre/madre del niño(a) y el proveedor de atención médica del niño(a), el programa ha desarrollado el siguiente plan de atención médica para satisfacer las necesidades individuales de

NOMBRE DEL NIÑO(A):	FECHA DE NACIMIENTO DEL NIÑO(A):
NOMBRE DEL PROVEEDOR DE ATENCIÓN MÉDICA DEL NIÑO(A):	☐ Médico ☐ Asistente Médico ☐ Enfermero(a) Practicante

Describa las necesidades especiales de atención médica de su hijo(a) y el plan de cuidado identificado por el padre/madre y el proveedor de atención médica del niño(a). Esto debería incluir informaciónn completada en la declaración médica concedida durante la inscripción o información complartida después de la inscripción.

Identifique a los proveedores del cuidado que ofrecerán atención a este niño(a) con necesidades especiales de salud:

Nombre del Proveedor del Cuidado	Credenciales o Información Sobre la Licencia Profesional (si se aplica)

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

PLAN INDIVIDUAL DE ATENCIÓN MEDICA PARA UN NIÑO(A) CON NECESIDADES ESPECIALES DE SALUD

Describa cualquier capacitación adicional, procedimientos o competencias que identificó el cuidador para llevar a cabo el plan de atención médica del niño(a) con necesidades especiales, según lo identificó el padre/madre o al proveedor del cuidado de atención médica del niño(a). Esto debe incluir la información completada en la declaración médica ofrecida al inscribirse o la información compartida después de ésta. Además, describa cómo se obtendrá esta capacitación adicional y competencia, incluido quién proveerá la capacitación.

Este plan se desarrolló en estrecha colaboración con los padres del niño(a) y el proveedor de atención médica del niño(a). Los cuidadores identificados para proporcionar todos los tratamientos y administrar medicamentos al niño(a) enumerado en el plan especializado de atención médica individual están familiarizados con las regulaciones de cuidado infantil y han recibido capacitación adicional necesaria y han demostrado competencia para administrar dicho tratamiento y medicamento de acuerdo con el plan identificado.

NOMBRE DEL PROGRAMA:	NÚMERO DE ID DEL ESTABLECIMIENTO:	NÚMERO DE TELÉFONO DEL PROGRAMA:
NOMBRE DEL PROVEEDOR DEL CUIDADO DEL NIÑO(A) (LETRA DE IMPRENTA):		FECHA:
FIRMA DEL PROVEEDOR DE ATENCION MÉDICA DEL NIÑO(A): **X**		

FIRMA DEL PADRE O MADRE:

	FECHA:
X	

ATTACHMENT 5

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: / /

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

PLAN DE EMERGENCIA INDIVIDUAL PARA ALERGIAS Y ANAFILAXIA

Instrucciones:

- Este formulario debe completarse para todo niño que tenga una alergia conocida.
- El programa de cuidado infantil debe trabajar con los padres/tutores legales y el proveedor de atención médica del niño para desarrollar instrucciones por escrito que describan a qué es alérgico el niño, y las estrategias de prevención y los pasos que deben seguirse si el niño estuviera expuesto a un alérgeno conocido o muestra síntomas de la exposición.
- Este plan debe revisarse al momento del ingreso, anualmente después del ingreso y cada vez que haya cambios de personal o voluntarios, o en cualquier momento que haya cambios en la información de las alergias o de los tratamientos del niño. Este documento debe adjuntarse al Plan Individual de Atención Médica del niño.
- Agregue más hojas si son necesarios más documentos o instrucciones.

Nombre del niño: Fecha del plan: / /

Fecha de nacimiento: / / Peso actual: lb

Asma: ☐ Sí (mayor riesgo por reacción) ☐ No

Mi hijo tiene reacciones a los siguientes alérgenos:

Alérgeno:	**Tipo de exposición**: (***es decir*, *por aire/contacto con la piel/consumo, etc.***):	**Los síntomas incluyen, entre otros:** (***Marque todo lo que aplique***).
		☐ Falta de aire, sibilancias o tos ☐ Piel pálida o azulada, desmayos, pulso débil, mareos ☐ Garganta cerrada o ronca, dificultad para respirar o tragar ☐ Hinchazón significativa de la lengua o los labios ☐ Muchas ronchas en el cuerpo, enrojecimiento generalizado ☐ Vómitos, diarrea ☐ Cambios en el comportamiento y llanto inconsolable ☐ Otros (especifique)
		☐ Falta de aire, sibilancias o tos ☐ Piel pálida o azulada, desmayos, pulso débil, mareos ☐ Garganta cerrada o ronca, dificultad para respirar o tragar ☐ Hinchazón significativa de la lengua o los labios ☐ Muchas ronchas en el cuerpo, enrojecimiento generalizado ☐ Vómitos, diarrea ☐ Cambios en el comportamiento y llanto inconsolable ☐ Otros (especifique)
		☐ Falta de aire, sibilancias o tos ☐ Piel pálida o azulada, desmayos, pulso débil, mareos ☐ Garganta cerrada o ronca, dificultad para respirar o tragar ☐ Hinchazón significativa de la lengua o los labios ☐ Muchas ronchas en el cuerpo, enrojecimiento generalizado ☐ Vómitos, diarrea ☐ Cambios en el comportamiento y llanto inconsolable ☐ Otros (especifique)

Si es POSIBLE que mi hijo haya estado expuesto a un alérgeno, para CUALQUIER síntoma:

☐ Dar epinefrina de inmediato

Si mi hijo DEFINITIVAMENTE estuvo expuesto a un alérgeno, incluso si no tiene síntomas:

☐ Dar epinefrina de inmediato

Fecha del plan: / /

SI EL NIÑO MUESTRA SÍNTOMAS, SE TOMARÁN LAS SIGUIENTES MEDIDAS, incluyendo pero no limitándose a lo siguiente:

- **Inyecte epinefrina de inmediato y anote la hora a la que le dio la primera dosis.**
- **Llame al 911/equipo de rescate local** (avise al 911 que el niño tiene anafilaxia y puede necesitar epinefrina cuando lleguen los socorristas).
- Recueste a la persona, levántele las piernas y manténgala caliente. Si tiene dificultades para respirar o está vomitando, permítale sentarse o recostarse de lado.
- Si los síntomas no mejoran o regresan, puede darle otra dosis de epinefrina consultando con el 911 primeramente o con los técnicos de emergencias médicas.
- Avise a los padres/tutores legales del niño y a los contactos de emergencia.
- Una vez que cumpla las necesidades del niño y de todos los demás a su cuidado, avise de inmediato a la oficina.

MEDICAMENTOS/DOSIS

- Epinefrina de marca o genérica:
- Dosis de epinefrina: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRACIÓN E INFORMACIÓN DE SEGURIDAD PARA LOS AUTOINYECTORES DE EPINEFRINA

Cuando administre epinefrina con un autoinyector siga estas directrices:

- No ponga el pulgar, los dedos o la mano sobre la punta del autoinyector ni lo inyecte en ninguna parte del cuerpo que no sea la parte media externa del muslo. Si un miembro del personal se inyecta accidentalmente, debe buscar atención médica en la sala de emergencias más cercana.
- Si utiliza un autoinyector en un niño pequeño, manténgale la pierna firmemente en posición antes y durante la inyección para evitar lesiones.
- La epinefrina puede inyectarse a través de la ropa, si es necesario.
- Llame al 911 de inmediato después de la inyección.

ALMACENAMIENTO DE LOS AUTOINYECTORES DE EPINEFRINA

- Todos los medicamentos deben mantenerse en su envase original etiquetado.
- Los medicamentos deben mantenerse en un área limpia que esté fuera del alcance de los niños.
- Todo el personal debe saber dónde están almacenados los medicamentos del niño.
- Mencione cualquier medicamento, como los autoinyectores de epinefrina, que pueda almacenarse en un área diferente.
- Explique aquí dónde se almacenarán los medicamentos:

PROGRAMAS CERTIFICADOS POR MAT/EMAT SOLAMENTE

Solo puede administrar los siguientes medicamentos el personal que aparece en el Plan de Atención Médica del programa como administradores de medicamentos. El personal debe tener al menos 18 años y tener certificados de primeros auxilios y reanimación cardiopulmonar (CPR) que cubran todas las edades de los niños bajo cuidado.

- Antihistamínico de marca o genérico:
- Dosis de antihistamínico:
- Otros (por ejemplo, inhalador broncodilatador, si tiene sibilancias):

***Nota: No dependa de antihistamínicos o inhaladores (broncodilatadores) para tratar una reacción grave. USE EPINEFRINA.**

ALMACENAMIENTO DE INHALADORES, ANTIHISTAMINESÍNICOS, BRONCODILATADORES

Todos los medicamentos deben mantenerse en su envase original etiquetado. Los medicamentos deben mantenerse en un área limpia que esté fuera del alcance de los niños. Todo el personal debe saber dónde están almacenados los medicamentos del niño. Explique dónde se almacenarán los medicamentos. Mencione cualquier medicamento, como inhaladores para el asma, que puedan almacenarse en un área diferente.

Explique aquí:

ESTRATEGIAS PARA REDUCIR EL RIESGO DE EXPOSICIÓN A DESENCADENANTES DE ALERGIAS
El programa de cuidado de niños usará las siguientes estrategias para minimizar el riesgo de exposición a cualquier alérgeno mientras el niño mencionado arriba esté bajo cuidado (agregue más hojas si es necesario):

El plan de documentos va aquí:

CONTACTOS DE EMERGENCIA: LLAME AL 911	
Ambulancia: ( ) -	
Proveedor de atención médica del niño:	N.° de teléfono: ( ) -
Padre/Madre/Tutor legal:	N.° de teléfono: ( ) -
CONTACTOS DE EMERGENCIA DEL NIÑO	
Nombre/Relación:	N.º de teléfono: ( ) -
Nombre/Relación:	N.º de teléfono: ( ) -
Nombre/Relación:	N.º de teléfono: ( ) -

Firma para la autorización del padre/madre/tutor legal:	Fecha: / /
Firma para la autorización del médico/proveedor de atención médica:	Fecha: / /
Firma para la autorización del programa:	Fecha: / /

ATTACHMENT 6

OCFS-4436 (5/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INCIDENT REPORT FOR CHILD DAY CARE

INSTRUCTIONS

- This form may be used to maintain a record of illnesses or injuries of a child while in care.
- This form may be used to notify parents of illnesses or injuries occurring with their children while in care.
- Please PRINT clearly and attach additional sheets if needed.
- **If death of a child occurs, you must immediately notify the Office of Children and Family Services Regional Office at 1-800-732-5207.**

Today's Date: _____ **License/Registration Number:** _____

Program Name: _____

Name of Child: _____ **DOB:** _____

(Please print full first and last name)

Details of Incident (Include date, time and location where incident occurred) (Due to confidentiality, the names of other children involved in any incident may not be shared with parent(s))

Injuries (Include a full description of any and all marks, bruises & abrasions)

Medical Services/Treatment Provided (Please include any and all treatment, listing who administered treatment)

(Continued on reverse)

Caregiver(s)

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Witnesses to the Incident

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Parent/Guardian Notified

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

Office of Children & Family Services Notified By

Name: _____ (PRINT Full Name) **Date:** _____ (MM/DD/YY) **Time:** _____ ☐ AM ☐ PM

_____ (Signature)

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

INFORME DE INCIDENTES PARA EL CUIDADO DIURNO DE NIÑOS

INSTRUCCIONES

- Este formulario puede utilizarse para mantener un registro de las enfermedades o lesiones de un niño(a) que está bajo cuidado infantil.
- Este formulario puede utilizarse para notificar a los padres o tutores sobre las enfermedades o lesiones ocurridas mientras su niño(a) está bajo cuidado infantil.
- Por favor escriba en LETRA DE IMPRENTA claramente y adjunte páginas adicionales si es necesario.
- **Si ocurre la muerte de un niño(a) mientras está bajo cuidado, usted debe notificar inmediatamente a la Oficina Regional de la Oficina de Servicios para Niños y Familias del Estado de Nueva York al 1-800-732-5207.**

Fecha de Hoy: _____ **No. de Licencia/Registro:** _____

Nombre del Programa: _____

Nombre del Niño(a): _____ **DOB:** _____
(ESCRIBA El NOMBRE COMPLETO EN LETRA DE IMPRENTA)

Detalles del Incidente: (Incluya la fecha, la hora y el lugar donde ocurrió el incidente). (Debido a asuntos de privacidad, los nombres de otros niños involucrados en cualquier incidente no se deben compartir con los padres del niño(a)).

Lesiones: (Incluya una descripción completa de cualquier marca, moretón y/o abrasión).

Servicios Médicos/Tratamiento Provisto: (Incluya cualquier tratamiento provisto e indique el nombre y el título de la persona que administró el tratamiento).

(Continúa en el reverso)

Proveedor(a) de Cuidado

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(Firma)

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)

Testigo del Incidente

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)

Padre/Madre/Tutor(a) Notificado(a)

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)

Persona que notificó a la Oficina de Servicios para Niños y Familias

Nombre: _____ **Fecha:** _____ **Hora:** _____ ☐ AM ☐ PM
(NOMBRE COMPLETO EN LETRA DE IMPRENTA) (MM/DD/YY)

_____
(FIRMA)