

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**HEALTH CARE PLAN FOR THE ADMINISTRATION OF MEDICATION  
FOR LEGALLY-EXEMPT PROVIDER**

**IMPORTANT! Provider, refer to the detailed instructions when completing this form.**

**SECTION I – PROVIDER’S INFORMATION**

Provide the information requested below.

PROVIDER’S NAME:	PROVIDERS PHONE NUMBER:
PROVIDER’S ADDRESS:	
ADDRESS WHERE CHILD CARE IS PROVIDED, IF DIFFERENT FROM ABOVE:	

**SECTION II – PROVIDER’S POLICY ON ADMINISTRATION OF MEDICATION TO CHILDREN IN CARE**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I tell parents/caretakers my policies and procedures for giving medicine to children when the parent/caretaker signs up and whenever the plan is changed.
<input type="checkbox"/>	<input type="checkbox"/>	I will let parents/caretakers read my <u>Health Care Plan for Administration of Medication</u> when they ask.

**SECTION IIA – QUALIFICATIONS OF THE PERSON(S) DESIGNATED TO GIVE MEDICATION**

Give the name and qualifications for the person designated to give medicine to children.

<b>A. Name:</b>												
<b>B. Title:</b>												
<b>C. Basic Requirements:</b> The designated person is: <input type="checkbox"/> 18 years of age or older <input type="checkbox"/> Able to read, write and speak the language that parental/caretaker’s permissions and health care provider’s instructions will be spoken and written in.												
<b>D. Qualifications:</b> (Indicate below what qualifications allow the designated person to give medicine) <b>1. Certified to Give Medicine – The person designated to give medicine meets the Office of Children and Family Services (OCFS) training requirements.</b> (Place a check in front of each training that was completed and give requested dates.) <table border="1" style="width:100%; margin-top: 10px; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;"></th> <th style="width:10%;">Certification date</th> <th style="width:10%;">Expiration date</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"><input type="checkbox"/> Cardio-pulmonary resuscitation (CPR)</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> First Aid</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Medication Administration Training (MAT)</td> <td></td> <td></td> </tr> </tbody> </table>		Certification date	Expiration date	<input type="checkbox"/> Cardio-pulmonary resuscitation (CPR)			<input type="checkbox"/> First Aid			<input type="checkbox"/> Medication Administration Training (MAT)		
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<input type="checkbox"/> Cardio-pulmonary resuscitation (CPR)												
<input type="checkbox"/> First Aid												
<input type="checkbox"/> Medication Administration Training (MAT)												
<b>2. Authorized – The person designated to give medicine is a trained medical professional with a license issued by NYS Department of Education or certification issued by the New York State (NYS) Department of Health.</b> (Provide details on the license/certification below.)  Type of license/certification: License/certification number: Expiration date:												

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**SECTION IIB – ADMINISTERING MEDICATION**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	The qualified person may give medicine only in the following ways: <ul style="list-style-type: none"> <li>• Topical</li> <li>• Oral</li> <li>• Eye</li> <li>• Ear</li> <li>• Inhaled</li> <li>• Medication patches</li> <li>• Epinephrine auto-injector devices (EpiPens®)</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	I will complete and follow an Individual Health Care Plan for a Child with Special Health Care Needs for any child who needs medicine which is given by any way that is not on the list.
<input type="checkbox"/>	<input type="checkbox"/>	The person designated to give medicine to children in child care will be on-site at all times. <i>If no, describe how children will receive their medicine when the designated staff person is not on site at all times, or is absent.</i>

**SECTION IIC – WHO MAY ADMINISTER MEDICATION**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Only a qualified selected, staff person may give children medicine that is not an over-the-counter topical ointment, sunscreen lotion, and/or topically applied insect repellent.
<input type="checkbox"/>	<input type="checkbox"/>	Anyone who is not qualified to give medicine may <i>only</i> give over-the-counter topical ointment, sunscreen lotion and topically applied insect repellent to children in care.
<input type="checkbox"/>	<input type="checkbox"/>	I will allow a parent/caretaker to give medicine to his/her child while in my care, if the parent/caretaker chooses to do so.
<input type="checkbox"/>	<input type="checkbox"/>	I will allow a parent/caretaker to select an adult family member to give medicine to his or her child. The only relatives allowed to give medicine to a child in care are the child’s: <ul style="list-style-type: none"> <li>• grandparents</li> <li>• great-grandparents</li> <li>• great-great-grandparents</li> <li>• aunt/uncle and spouses</li> <li>• great aunt/uncle and spouses</li> <li>• brother/sister</li> <li>• first cousin and spouse</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	I will allow a parent/caretaker to select a member of the child’s household to give medicine to his or her child.
<input type="checkbox"/>	<input type="checkbox"/>	I will allow a parent/caretaker to select a New York State licensed medical professional to give medicine to his or her child.
<input type="checkbox"/>	<input type="checkbox"/>	The parent/caretaker must inform me in writing of any person he or she has selected to give medicine to his or her child.

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**SECTION IID – PARENTAL/CARETAKER PERMISSION AND HEALTH CARE PROVIDER’S INSTRUCTIONS BEFORE GIVING OUT MEDICINE**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will follow all OCFS rules for getting and keeping records of parental/caretaker’s permission and health care provider instructions.
<input type="checkbox"/>	<input type="checkbox"/>	Before giving medicine to a child, I will have the parent’s/caretaker’s permission.
<input type="checkbox"/>	<input type="checkbox"/>	Before giving medicine to a child, I will get instructions from the health care provider, whenever it is required by OCFS.
<input type="checkbox"/>	<input type="checkbox"/>	I will always have either the <u>Written Medication Consent Form</u> or the <u>Verbal Medication Consent Form</u> .

**Giving over-the-counter medicine when a child develops symptoms while at your program and you do not have written parental/caretaker’s permission or health care provider instructions -**

If you plan to give over-the-counter medicine to a child who develops symptoms and you do not have written parental/caretaker’s permission or health care provider instructions, you must agree to do the following before giving the medicine.

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<b>For children up to 18 months of age:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	I will get written parent/caretaker permission and health care provider instructions to administer all over-the-counter medicine, except topical ointments, sunscreen and topically applied insect repellent.
<input type="checkbox"/>	<input type="checkbox"/>	For over-the-counter topical ointments, sunscreen and topically applied insect repellent, I will get verbal parental/caretaker’s permission which must match the instructions for use written on the medicine container.
<b>For children over 18 months of age:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	For all over-the-counter medicine, I will get verbal parental/caretaker’s permission which must match the instructions for use written on the medicine container.
<b>For all children:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	I will document all permission and instructions received.
<input type="checkbox"/>	<input type="checkbox"/>	When receiving verbal instructions from the health care provider, I will ask that the health care provider to send written instructions to me.
<input type="checkbox"/>	<input type="checkbox"/>	I will check for special instructions on the container that are age-specific.

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Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will follow the instructions on the container when I give the over-the-counter medicine/ointment.
<input type="checkbox"/>	<input type="checkbox"/>	I will not give the medicine on the following days unless I have the proper permission and instructions required to give medicine on an on-going basis.

**Giving medicine when a child has symptoms upon arrival at your program, but there are no written health care provider instructions -**

**If you plan to give over-the-counter medicine or prescription medicine to a child when the parent/caretaker arrives at your program but does not have written health care provider instructions, you must agree to do the following before giving the medicine.**

**The provider understands and agrees to the following:** (Check "Yes" or "No" for each statement, based on your policy and procedure.)

Yes	No	
<b>For children up to 18 months of age for over-the-counter-medicine:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	I will get written parent/caretaker permission and health care provider instructions to administer all over-the-counter medicine, except topical ointments, sunscreen and topically applied insect repellent.
<input type="checkbox"/>	<input type="checkbox"/>	For over-the-counter topical ointments, sunscreen and topically applied insect repellent, I will get written parental/caretaker's permission which must match the instructions for use written on the medicine container.

**For children up to 18 months of age for prescription medicine:**

<input type="checkbox"/>	<input type="checkbox"/>	I will get verbal parental/caretaker permission and health care provider instructions to administer all prescription medicine.
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**For children over 18 months of age for over-the-counter medicine:**

<input type="checkbox"/>	<input type="checkbox"/>	I will get verbal parental/caretaker permission, which must match the instructions for use written on the medicine container.
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**For children over 18 months of age for prescription medicine:**

<input type="checkbox"/>	<input type="checkbox"/>	I will get verbal parental/caretaker permission and health care provider instructions to give all prescription medicine.
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**For all children:**

<input type="checkbox"/>	<input type="checkbox"/>	I will document all permission and instructions received.
<input type="checkbox"/>	<input type="checkbox"/>	When receiving verbal instructions from the health care provider, I will ask the health care provider to send written instructions to me.
<input type="checkbox"/>	<input type="checkbox"/>	I will check for special instructions on the container that are age-specific.
<input type="checkbox"/>	<input type="checkbox"/>	I will follow the instructions on the container when I give the over-the-counter medicine/ointment.
<input type="checkbox"/>	<input type="checkbox"/>	I will not give the medicine on the following days unless I have the proper permission and instructions required to give medicine on an on-going basis.

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**SECTION IIE – KEEPING TRACK OF MEDICINE DOSAGES AND TIME**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	For <b>each child</b> who receives medicine while in my care, I will keep log sheets with the child’s name on them. I will do this on the <u>Log of Administration</u> form.
<input type="checkbox"/>	<input type="checkbox"/>	Each time medicine is given, the person who gives the medicine will record on the log for that child: <ul style="list-style-type: none"> <li>• the medicine given,</li> <li>• the amount given (dosage)</li> <li>• the date and time it is given, and</li> <li>• his or her signature.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	If any mistake is made giving medicine, I will report it to the child’s parent/caretaker immediately. I will tell the parent/caretaker to tell the child’s health care provider.
<input type="checkbox"/>	<input type="checkbox"/>	If any mistake is made giving medicine, I will report it to OCFS by the following business day, using the <u>Medication Error Report Form</u> . (Report this to the Bureau of Early Childhood Services at the OCFS Regional Office, or in New York City (NYC) to the Bureau of Day Care at the NYC Department of Health and Mental Hygiene (DOHMH). The contact information for Regional Offices and NYC DOHMH can be found in the instructions or by visiting the following internet site: <a href="http://www.ocfs.state.ny.us/main/beccs/regionaloffices.asp">http://www.ocfs.state.ny.us/main/beccs/regionaloffices.asp</a> .)
<input type="checkbox"/>	<input type="checkbox"/>	When a child has side effects to a medicine, I will tell the child’s parent/caretaker. I will write all side effects on the <u>Log of Administration</u> . I will report side effects to the health care provider when appropriate. I will get medical help if needed.
<input type="checkbox"/>	<input type="checkbox"/>	When I give any “as needed” medicine to a child, I will tell the child’s parent/caretaker. I will record this on the <u>Log of Administration</u> .
<input type="checkbox"/>	<input type="checkbox"/>	When the health care provider’s instructions for giving a medicine are not the same as the ones on the label, I have a way to let the person who gives medicine know this. My plan is:
		I know that changes can only be made to: <ul style="list-style-type: none"> <li>• the dose amount,</li> <li>• the time the medicine was given, and</li> <li>• how often it is given.</li> </ul>

**SECTION IIF – STORAGE AND DISPOSAL OF MEDICINE**

The provider understands and agrees to the following: (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will keep all medicine (prescription and over-the-counter) in the original, labeled bottles. I will not give children any medicine that is not in its original bottle.
<input type="checkbox"/>	<input type="checkbox"/>	I will store <u>all medicine</u> in a clean, safe place that children cannot reach or get into. <i>Explain where you store medicine.</i> _____

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Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	When medicine needs to be refrigerated, I will keep it in a refrigerator.
<input type="checkbox"/>	<input type="checkbox"/>	When medicine is refrigerated, I will keep it separated from food by storing it in a <ul style="list-style-type: none"> <li>• a separate refrigerator used for medicine only, OR</li> <li>• a larger, sealed, leak-proof container in the refrigerator.</li> </ul> If no, describe how you keep medicine separate from food: _____
<input type="checkbox"/>	<input type="checkbox"/>	I will return out-of-date or leftover medicine to the parent/caretaker.
<input type="checkbox"/>	<input type="checkbox"/>	If a parent/caretaker(s) does not take the medicine, I will throw the medicine out in a way that it is safe (e.g., flush it down the toilet, or wash it down the sink).

**SECTION IIG – STOCK MEDICATION PROCEDURES**

Complete this section **ONLY** if you wish to be permitted to keep “stock” medications (medicine). Stock medicines are over-the-counter (non-prescription) medicines that are used when a child gets sick unexpectedly, while in your care.

You may keep a supply of stock medicine for children only if your Health Care Consultant approves of your policies and procedures stated in this section.

**I wish to keep a supply of “stock” medicine, and I agree to the following:** (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will not stock any <i>prescription</i> medicine, including EpiPens®.
<input type="checkbox"/>	<input type="checkbox"/>	I will use the procedures stated in this plan for “Storage and Disposal of Medicine” for my “stock” medicine.
<input type="checkbox"/>	<input type="checkbox"/>	I will not keep stock medication in the same place where I keep any “child specific” medication.
<input type="checkbox"/>	<input type="checkbox"/>	I will keep all stock medicine in the original container with the following information: <ul style="list-style-type: none"> <li>• Name of medicine,</li> <li>• Reasons for use,</li> <li>• Directions for how to use,</li> <li>• Dosage instructions,</li> <li>• Possible side effects,</li> <li>• Bad reactions or warnings, and</li> <li>• Expiration date</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	When giving stock medicine, I will follow the directions on the package.
<input type="checkbox"/>	<input type="checkbox"/>	When I remove stock medicine from the original container to a measuring spoon or other measuring tool, I will do it in a way that will not contaminate the stock medicine.
<input type="checkbox"/>	<input type="checkbox"/>	Stock medicine is given to each child with a medicine cup, spoon or other measuring tool, which is used only for that child. I will label each measuring tool with the child’s name.
<input type="checkbox"/>	<input type="checkbox"/>	I will follow all regulations related to parent/caretaker or guardian permissions and health care provider instructions.

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Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will give a stock medicine to a non-infant child, based on verbal permission of the parent/caretaker or guardian for one day only. I will require written permission to give stock medicine for more than one day.
<input type="checkbox"/>	<input type="checkbox"/>	For an infant child, I will only give topical stock medicine for one day based on verbal permission of the parent/caretaker or guardian. Any stock medicine, other than topical, will be given only with written permission from the parent/ caretaker/guardian and written instructions from the health care provider.

**SECTION IIIH – INDIVIDUAL HEALTH CARE PLAN FOR A CHILD**

**The provider understands and agrees to the following:** (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	When caring for a child with special health care needs, I will work with the parent/caretaker and health care provider to develop an <u>Individual Health Care Plan for a Child with Special Health Care Needs</u> .
<input type="checkbox"/>	<input type="checkbox"/>	When caring for a child whose medicine cannot be given through the approved ways (routes), I will work with the child’s parent/care and health care provider to develop an <u>Individual Health Care Plan for a Child with Special Health Care Needs</u> .
<input type="checkbox"/>	<input type="checkbox"/>	When I am caring for a child who is allowed to independently administer his or her own medicine, I must follow an <u>Individual Health Care Plan for a Child with Special Health Care Needs</u> . The child’s plan must include: <ul style="list-style-type: none"> <li>• How the medicine will be stored and kept out of reach of other children,</li> <li>• How the child will make me aware of any medicine dose that he/she takes,</li> <li>• How I will document each dose the child takes,</li> <li>• How I will recognize possible side effects,</li> <li>• The actions to take if any side effects occur, and</li> <li>• Any additional training I may need to care for the child.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	When caring for a child who has an individual health care plan, I will follow the written procedures in the child’s plan.
<input type="checkbox"/>	<input type="checkbox"/>	When caring for a child with an individual health care plan, I will obtain any training that is needed to carry out the child’s plan.

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**SECTION III – EMERGENCY PROCEDURES**

Describe your procedures for obtaining emergency health care for children who need emergency care.

If not explained above, how will children be transported for emergency care?

How will any children remaining in care be supervised?

**SECTION IV – FIRST AID KIT**

You must have a well stocked first aid kit with items to treat different types of injuries, like cuts, scrapes, or bruises.  
List the contents of your first aid kit.

**SECTION V – INFECTION CONTROL PROCEDURE**

*Please read and sign below.*

I have reviewed the materials provided in the enrollment package, including those on

- Hand washing procedures
- Diapering procedures
- Safety precautions related to blood
- Proper gloving procedures
- Procedures and schedules for the sanitation of equipment, toys and objects.

My staff and I will follow these procedures when caring for children in my child care program.

PROVIDER'S SIGNATURE	DATE
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**SECTION VI – CHANGES TO THE HEALTH CARE PLAN FOR ADMINISTRATION OF MEDICATION**

There are four kinds of changes to the plan: updates, renewals, amendments and revocations.

**The provider understands and agrees to the following:** (Check “Yes” or “No” for each statement, based on your policy and procedure.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I will update the section for “Qualifications of the Person Designated to Administer Medications” by: <ul style="list-style-type: none"> <li>• Making sure that the person designated to give medicine attends training to renew his or her certifications in MAT, CPR, and First Aid, and</li> <li>• Adding the dates of recertification and certificate expiration for each of the three required trainings in my plan, and</li> <li>• Keeping the original certificates of completion for each training,</li> </ul> <b>OR</b> <ul style="list-style-type: none"> <li>• When the person designated to give medicine is a licensed medical professional, I will record the new expiration date of the license and keep a copy of the license on file.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	I will show the certificates and updates to my Health Care Consultant upon request.
<input type="checkbox"/>	<input type="checkbox"/>	I will renew my <u>Health Care Plan for Administration of Medication</u> every two years, if I want to continue giving medicine at my child care program. <ul style="list-style-type: none"> <li>• I will complete a new plan including all updates and changes.</li> <li>• I will have a health consultant visit my child care program at least once every two years.</li> <li>• A health care consultant will review and approve the revised plan.</li> <li>• I will submit the approval page to the local district or in NYC, the Human Resources Administration (HRA) or Administration for Children’s Services (ACS).</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	I will amend my <u>Health Care Plan for Administration of Medication</u> when my policies and procedures for giving medicine need to change. <ul style="list-style-type: none"> <li>• I will change the <u>Health Care Plan for Administration of Medication</u>.</li> <li>• A health care consultant will review and approve the amended plan</li> <li>• I will submit the new approval page to the local district, or in NYC, the HRA or ACS.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	If my Health Care Consultant revokes my Health Care Plan for Administration of Medication, I will tell the parent/ caretaker of all children in my care and the local district, or in NYC, the HRA or ACS, right away.

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**SECTION VII – CERTIFICATION AND SIGNATURE OF THE PROVIDER**

*You must read and sign the attestation below.*

- I understand that I must have a Health Care Consultant visit the site of my child care program and that I must obtain the approval of a Health Care Consultant before putting this Health Care Plan for Administration of Medication into effect.
- I understand that it is my responsibility to make sure this Health Care Plan for Administration of Medication is followed once it is approved by the Health Care Consultant.
- I understand that if there is only one person designated to give medicine and that person leaves my program, I must tell the parent/caretaker immediately that my child care program cannot continue to give medicine, other than over-the-counter topical ointments, sunscreen and topically applied insect repellent. I must also tell the local district.
- I understand that the approval of this plan and the authorization to give medicine applies only to children receiving child care subsidy and permits the designated person to give medicines only as part of this child care program.
- I understand that if I need to make any changes or revisions to my Health Care Plan for Administration of Medication, the Health Care Consultant must review and approve these changes. Once approved by the Health Care Consultant, I will notify parent/caretaker/guardians of the changes made to the health care plan. I will then submit the approval page from my Health Care Plan for Administration of Medication to the district.
- I understand that I must submit a copy of the approval page of my Health Care Plan for Administration of Medication to the local district or in NYC, the HRA or ACS, at the following times:
  - when my plan is approved,
  - when my plan is renewed,
  - when my plan is amended,
  - upon the request of the local district, or in NYC, the HRA or ACS.
- I understand and agree that if I am caring for a child with special health care needs, I will work with the child's parent/caretaker and health care provider to make an Individual Health Care Plan for a Child with Special Health Care Needs.
- I agree to notify the child's parent/caretaker, immediately, and the regional office of the Office of Children and Family Services, or in NYC the Department of Health and Mental Hygiene, by the close of the following business day, of any errors in giving medicine.
- If my Health Care Plan for Administration of Medication is revoked for any reason I agree to immediately notify:
  - the parent/caretaker of any child in my care, AND
  - my local district OR, in NYC, the HRA or ACS, as appropriate.
- I understand that I am responsible for paying my Health Care Consultant.
- I understand that if my plan is revoked, medicine cannot be given as part of my child care program.
- I understand that the Office of Children and Family Services may prohibit a provider or employee/volunteer from giving medicine or may require retraining of a provider or employee/volunteer who has failed to comply with the requirements for administration of medication set forth in regulation (18 NYCRR, Part 415.4(f)(7)(iv)(z).

PROVIDER'S SIGNATURE	DATE:
PROVIDER'S NAME (PLEASE PRINT):	

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**SECTION VIII – APPROVAL OF THE HEALTH CARE PLAN FOR ADMINISTRATION OF MEDICATION**

*The Health Care Consultant must review and sign the attestation below.*

In signing this document I understand:

- I am responsible for reviewing the policies and procedures for the administration of medication to children in this child care program who are receiving child care subsidy, as set forth in this Health Care Plan for Administration of Medication. This review process includes a site visit and the verification of staff qualifications for all staff designated to give medicine, including:
  - The review of documents that show the individuals have the necessary professional license or have completed the required training,
  - Proof that the person giving the medicine is at least 18 years of age, and
  - A determination that the person giving the medicine is literate in the language that the health care provider’s instructions and the parent’s/caretaker’s permissions are provided.
- I have determined that this Health Care Plan for Administration of Medication meets the requirements set forth in regulation, 18 NYCRR, Part 415.4(f)(7)(iv)(z), and my signature constitutes approval of this plan.
- **I approve, or I disapprove** (*choose one*) this program’s procedures for use of “stock” medication. I may call the OCFS regional office if I need additional information regarding the regulatory requirement.
- I may revoke my approval of this plan. If I do revoke my approval of the Health Care Plan for Administration of Medication, for any reason, I must notify the provider immediately. I may also notify the local district department of social services, or in NYC, HRA or ACS, of this revocation.
- I need to visit the program site at least once every two years, or more frequently if the Health Care Plan for Administration of Medication changes.
- I have a valid New York State license to practice as a physician, physician assistant, nurse practitioner, or registered nurse.

HEALTH CARE CONSULTANT SIGNATURE	DATE SIGNED (PLAN APPROVAL DATE)
HEALTH CARE CONSULTANT NAME (PLEASE PRINT)	LICENSE NUMBER
TITLE	LICENSE EXPIRATION DATE
ADDRESS	PHONE NUMBER

**SECTION IX – LOCAL DISTRICT REVIEW**

***Submit a copy of this completed approval page to your local district, or in NYC to HRA or ACS.***