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Medication Policy

Health Assessments

A copy of your child's physical and immunizations **must be received** no later than 30 days after your child begins the program. Families are responsible for assuring that their child's physicals are kept up-to-date and that a copy of the results of the child's health assessment is given to the program. Health Assessments for each child are also required according to the recommendations of the American Academy of Pediatrics (2mo, 4mo, 6mo, 9mo, 12mo, 15mo, 18mo, 2yr, 3yr, 4r, 5yr) (STATE LAW -3270.131).

Illnesses

Children may not attend school if they show any signs of a contagious illness. Staff will notify parents when a child is ill. Parents have 1 hour to pick up the ill child. Should parents not arrive within the 1-hour period the child's emergency contact person will be notified. Children must be symptom free or no longer contagious to return to school. Children who are sent home due to illness 2 consecutive days with symptoms of a communicable disease or infection will be unable to attend childcare until notification from a physician or CRNP that the child may return to care. (STATE LAW-3270.137)

Your child may not attend school with:	Your child may return to school when:
A temperature of 101 or higher	Fever free for 24hrs (w/o the influence of medication)
1 watery diarrhea or 3 loose BM within 24 hours	Symptom free for 12 hours
Vomiting	Symptom free for 12 hours
Persistent, phlegmy cough, extreme crankiness or lethargy combined with any fever, difficulties breathing, any other signs of contagious illness	All symptoms have passed
Symptoms of pinkeye (conjunctivitis) including 'glued' shut eyes, bright red eyes, oozing yellow/green from eyes, etc.	A doctor's note or after 24hrs on an antibiotic
Suspicion of Hand, Foot & Mouth, or chicken pox	Fever Free and a doctor's note or after all sores have scabbed
Signs of head lice including bugs or eggs found in hair	A doctor's note or after hair has been treated and no eggs or bugs are visible in hair

Medication

Staff will not administer any medication unless for a chronic ongoing condition/special needs. In such case, all medication must be logged on the medication log sheet. Medication must be in its original container with a prescription label containing the child's name, dosage, time of day medication to be administered, and expiration date. Medication should never be left in child's cubby or diaper bag. All medications must be handed directly to the director. (STATE LAW-3270.133)

Communicable Diseases

When an enrolled child or an employee of the center has a (suspected) reportable disease, it is our legal responsibility to notify the local Board of Health or Department of Public Health. We will take care to notify families about exposure, so children can receive preventive treatments.

Care Plans- Caring for Our Children

Children with special health care needs are defined as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally". Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home.

The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

YES NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)

HEARING (subjective until age 4)

LEAD

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:

ADDRESS:

PHONE:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

TITLE:

LICENSE NUMBER:

DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

**SCHOOL COPY- PLEASE SIGN AND RETURN
ACCIDENT / BEHAVIOR REPORT**

CHILD'S FULL NAME: _____

DATE: _____ TIME: _____

DESCRIPTION OF THE INCIDENT:

CLASSROOM: Secondary / Primary / Junior / Nursery Inside / Outside: _____

HOW: ___ Trip/Fall ___ Kick/Hit ___ Bite ___ "I Noticed..." ___ Unknown/Other: _____

Did it involve another child? Yes / No If yes, explain: _____

WHAT: ___ Cut/Scrape/Scratch ___ Bump/Bruise/Red Mark ___ Splinter Other: _____

WHERE: Where on child? ___ head ___ other: _____

ACTION TAKEN:

___ Ice ___ Washed soap & water ___ BandAid ___ Comforted ___ Consequence

Other: _____

FOLLOW UP: Time: _____ Description: _____

TEACHER/AIDE SIGNATURE: _____

I have read the above report and have discussed the incident with a teacher involved. I understand that in many cases, sign of visible injury do not show up or may change appearance after the incident has occurred. In this case, I find the description above to be a truthful and valid representation of what actually took place.

PARENT SIGNATURE: _____

PARENT COPY

ACCIDENT / BEHAVIOR REPORT

CHILD'S FULL NAME: _____

DATE: _____ TIME: _____

DESCRIPTION OF THE INCIDENT:

CLASSROOM: Secondary / Primary / Junior / Nursery Inside / Outside: _____

HOW: ___ Trip/Fall ___ Kick/Hit ___ Bite ___ "I Noticed..." ___ Unknown/Other: _____

Did it involve another child? Yes / No If yes, explain: _____

WHAT: ___ Cut/Scrape/Scratch ___ Bump/Bruise/Red Mark ___ Splinter Other: _____

WHERE: Where on child? ___ head ___ other: _____

ACTION TAKEN:

___ Ice ___ Washed soap & water ___ BandAid ___ Comforted ___ Consequence

Other: _____

FOLLOW UP: Time: _____ Description: _____

TEACHER/AIDE SIGNATURE: _____

I have read the above report and have discussed the incident with a teacher involved. I understand that in many cases, sign of visible injury do not show up or may change appearance after the incident has occurred. In this case, I find the description above to be a truthful and valid representation of what actually took place.

Permission for Medical Condition Treatment

Parent or Guardian signature indicates permission for child care provider to follow these instructions:

(Parent Signature)

TO: Facility name _____ Phone: _____
Address: _____ Fax: _____

Child's name: _____	Date of Birth: _____
Address: _____	
Medical condition(s) of concern: _____	

Signs and/or symptom(s) to watch for: _____	
Medications: _____	Dose: _____
How given: _____	When given? _____
Possible side effects: _____	
Temporary program adaptations: _____	

When to call parent/health provider regarding symptoms or failure to respond to treatment:	

When to consider that the condition requires urgent care or reassessment:	

FROM: Health care provider: _____ Phone: _____
Address: _____
Date of exam: _____

ADMINISTRATION OF MEDICATIONS / SPECIAL DIETARY NEEDS RELEASE FORM

Child's Name: _____

Date: _____

Please circle YES or NO for the following according to your child's individual needs. It is the parent's responsibility to inform K-Prep in writing of any changes to this form or any other medical/dietary needs.

My child is need of regular medication as stated below. YES / NO

My child has special dietary needs as stated below. YES / NO

Parent signature _____ date _____

Medication:

Name of medication: _____ Copy of prescription attached: YES / NO

Prescriber's name: _____ Phone #: _____

Prescription Details (amount, time to be given, frequency, etc): _____

Symptoms signaling need for administration (if as needed): _____

Medication indications: _____

I give permission for K-Prep staff to administer medication to my child as stated above. I understand all administrations will be listed on the medication log. I do not hold K-Prep or any individual staff member responsible for any complications of this medication. I understand an updated prescription is required for administration of this medication. I understand it is my responsibility to update this medication release form if there is ANY change in my child's medication needs.

Parent signature _____ date _____

Special Dietary Needs:

Please explain dietary needs IN DETAIL specific to your child.

The above are the dietary needs for my child. I do not hold K-Prep or any individual staff member responsible for any complications that may arise due to the above dietary needs and/or any reactions to food/drink not listed above. I understand that it is my responsibility to update this dietary needs release form if there are ANY changes in my child's dietary needs.

Parent signature _____ date _____

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133
PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

Prescription Non-Prescription

Refrigeration Required: YES NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ To _____
Date Date

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

I give permission to administer medication to my child as stated above.

Parent Signature _____

Date _____

FACILITY STAFF COMPLETE THIS SECTION

Date Administered (mm/dd/yyyy)	Time Administered (a.m. / p.m.)	Amount of Medication Administered	Comments/Reactions	Staff Initials

This information is confidential and may not be shared or released without the parent's written permission.



Inclusion

K-Prep Learning Center believes that children of all ability levels are entitled to the same opportunities for participation, acceptance and belonging in child care. We will make every reasonable accommodation to encourage full and active participation of children in our program based on his/her individual capabilities and needs.

IEP/IFSP implementation policy

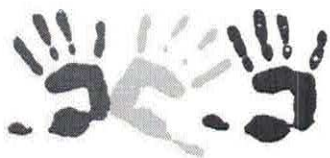
In order to ensure that the needs of children with an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP) are met, the following procedures will be implemented.

Director will:

- Ask all families to complete a request form for a copy of a child's IEP/IFSP. This request will be placed in each child's file.
- File all copies of IEP/IFSPs in child's file in order to be readily available to share with teaching team.
- Provide copies of IEP/IFSP goals to the child's teacher(s) and discuss strategies for meeting the goals.
- Ensure all teachers are trained on how to implement an IEP/IFSP. Training will be documented in each teacher's professional development record (PDR).
- Work with early intervention staff/consultants to schedule periodic meetings with child's family and teacher(s) to discuss the child's progress and to increase strategies in adapting IEP/IFSP goals in classroom activities and routines.
- Request permission from families to attend any meetings with the early intervention team related to changes to the IEP/IFSP.
- Monitor teachers' work towards supporting the child in meeting IEP/IFSP goals.
- Request additional help from early intervention team if needed.
- Ensure teachers conduct family conferences to report on progress.

Teaching Team will:

- Observe and document the child's progress towards goals weekly and use their notes to individualize lesson plans.
- Complete a communication log between home and the teachers daily for each child with an IEP/IFSP.
- Prepare for and conduct family conferences at least 3 times a year to share progress on IEP/IFSP goals, the child's development, and participation in the classroom.
- Meet with the family to plan for and discuss transitioning to new classrooms or programs. An individualized plan will be created as needed to ensure successful transition for the child.



K-Prep Learning Center
3943 Columbia Avenue, Columbia, PA 17512 717-285-2711

After careful screening of your child in areas of language, physical development and social-emotional growth, the educators at K-Prep are recommending your child have more detailed evaluations outside of K-Prep Learning Center. A request for an evaluation at an outside organization does not assume a need for intervention, it is only a recommendation for further observations and information. As the primary caregiver, you can choose how to proceed.

Please sign the bottom of this form, acknowledging this recommendation and indicating if you are choosing to follow the recommendation by K-Prep Learning Center.

Child's Name _____ Date of Birth _____

K-Prep Learning Center is recommending contacting the following organization:

___ I WILL follow the recommendations of K-Prep Learning Center and I will contact the above organization, or an affiliate within 30 days. I will share with K-Prep Learning Center a letter stating the results of the interaction. For example, if an appointment is made, families will request a letter from an organization detailing the next steps in the evaluation. If the organization feels there is no need for any further action, a letter stating that result will be given to K-Prep Learning Center.

___ I will NOT follow the recommendations of K-Prep Learning Center at this time.

Parent Signature Date

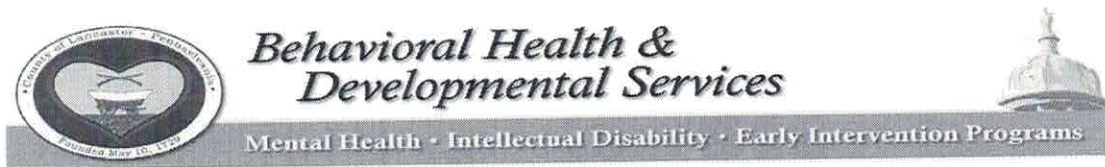
Director Signature Date of recommendation

Special Needs

All children are welcome at K-Prep Learning Center.

We work with therapists from IU-13, Early Intervention, Schreiber Center, and private organizations. Our staff are trained in appropriate inclusion practices, and on procedures to conduct regular development screenings in language, physical development and social & emotional growth. If a student has an Individual Education Plan (IEP) or Individual Family Studies Plan (IFSP), we keep a copy on file for reference on best learning strategies and documented progress.

Within the first 45 days of enrollment, all students are screened in all areas of development. At this time, parents are invited to schedule an initial meeting to discuss development and adjustment to a new childcare setting. Screenings are continued at regular intervals during a student's enrollment. *Parents are encouraged to discuss screenings with teachers and directors at any time.*



Lancaster County Early Intervention

717-399-7323 HMREarlyInt@co.lancaster.pa.us

Statewide CONNECT line: 1-800-692-7288

Early Intervention provides services and supports to families with children who have developmental delays. Supports are based on the unique strengths and needs of the child and family to enhance the child's development. Supports are designed to:

- Answer questions about your child's development
- Assist you and your child throughout daily routines at home and in the community
- Enhance your child's development and educational growth
- Support your child to become more independent
- Provide awareness in the community about the gifts and abilities of all children
- Prevent costly intervention in the future

Early Childhood &
Special Education
Services | **iu13**

Lancaster Lebanon Intermediate Unit 13

888-745-0771 specialeducation@iu13.org

The Early Intervention Program of IU13 provides support and services to children, from age three to age five, with disabilities and the need for specially designed instruction. Children may be eligible for Preschool Special Education by meeting the criteria for one of several disability categories including, but not limited to, speech or language impairment, developmental delay and emotional disturbance. For children determined eligible for Preschool Early Intervention, an Individualized Education Program (IEP) is developed to determine the appropriate supports and services. Early Intervention services must be delivered in the setting(s) consistent with the educational needs of the child. Services may be provided in settings such as, but not limited to, local childcare centers, community preschools, Head Start Programs, specialized settings, or in the home.

