Faith Child Care and Nursery School

Cleaning and Sanitizing

Equipment, toys and objects used or touched by children will be cleaned and sanitized as follows:

1. Equipment that is frequently used or touched by children will be cleaned and disinfected when soiled and at least once weekly.
2. Carpets contaminated with body fluids must be spot cleaned.
3. Diapering surfaces must be disinfected after each child.
4. Countertops, tables and food preparation surfaces (including cutting boards) must be cleaned and disinfected before and after food preparation and eating.
5. Potty chairs will not be used. Toilet training children will use the child size toilets.
6. Toilet facilities must be kept clean at all times, and must be supplied with toilet paper, soap, and disposable towels accessible to the children.
7. Any surface which comes in contact with body fluids must be disinfected immediately.
8. Thermometers and toys mouthed by children must be disinfected before use by another child.

Staff will use the following procedures for cleaning and sanitizing non-porous hard surfaces such as tables, countertops and diapering surfaces:

1. Wash the surface with soap and water.
2. Rinse until clear.
3. Spray the surface with the EPA registered spray. Enviro Care #47371-131-527.
4. Let it sit for 1 minute.
5. Wipe with a paper towel or let air-dry.

Staff will use the following procedure to clean and disinfect toys that have been mouthed by children:

1. Wash the toys in warm soapy water, using a scrub brush if necessary to reach crevices.
2. Rinse in running water until water runs clear.
3. Place toys in soaking solution of hospital-grade germicide or spray thoroughly with hospital-grade germicidal spray.
4. Soak or let sit for at least 5 minutes.
5. Rinse with cool water.
6. Let toys air-dry.

OR

1. Wash toys in sanitizing dishwaher.
2. Let toys air-dry.

Stock (non-child specific) Medication Protocol

The program will not stock prescription medication

Stock medication will be kept in a clean area that is inaccessible to children. In addition, all stock medication will be stored separately from child specific medication.

Stock medications will be stored in a bin labeled "Stock Medications" that will be stored next to the child specific medications.

Stock medication will be kept in the original container and have the following information on the label or in the package insert:

- Name of the medication
- Reasons for use
- Directions for use including route of administration
- Dosage instructions
- Possible side effects and/or adverse reactions
- Warnings or conditions under which it is inadvisable to administer the medication (contraindications)
- Expiration date

Stock medication that is not in single dose packaging will have a mechanism in place to provide a separate device to administer the medication for each child that may need the medication. Once the device has been used for the child (for example: a medicine cup, dosing spoon, oral syringe, etc) it may be disposed of or reused only for that specific child and will be labeled with the child's first and last name.

In addition, the program will include the procedure for dispensing the stock medication from the container to the device or directly administering to the child without contaminating the stock medication.

Staff will follow best practice procedures taught in the MAT program and administer stock medication using best practice techniques in accordance with the directions for use on the medication package. Additionally, the program will limit stocked medication to OTC oral liquids, pills/capsules, and creams/ointments.

There will be a supply of individually wrapped medicine cups, dosing spoons, and oral syringes for oral liquids & drops so that children do not share administration devices. The Program will follow all regulations related to parent or guardian permissions and health care provider instructions.

Faith Child Care &Nursery School-Stock Epinephrine Auto-injector trained staff				
Name	MAT Exp	CPR Exp	FA Exp	Anaphylaxis Cert
Carli Lo Cigno				03-08-2024
Bonnie Samuels				04-18-2024
Micaela White				12-04-2023

License Information- Pulled 3/28/2024
BROWN TRACEY MONIQUE

L

Address
ROCHESTER NY
Profession
Registered Professional Nursing (022)
License Number
519072
Date of Licensure
October 16, 2000
Status
Registered
Registered through Date
February 28, 2027
Additional Qualifications

- None

Additional Licenses

- Licensed Practical Nursing (010) license # 217243

Child's Name ______________________________

FAITH CHILD CARE & NURSERY SCHOOL

2576 Browncroft Blvd., Rochester, NY 14625

PARENT PERMISSIONS AND AGREEMENT

Parent Handbook

I agree to abide by the policies and procedures as stated in the FCCNS Parent Handbook which is distributed. These documents are also available on the FCCNS website. I understand that there are hard copies available in the FCCNS office if this is my preference.

Initial__________

Health Related Documents

I received/read the documents below, which have been distributed. These documents are also available on the FCCNS website. I understand that there are hard copies available in the FCCNS office if this is my preference.

Health Care Plan________(initials) **Anaphylaxis Policy**__________ (initials)

Student information sharing

Occasionally parents ask for information about their child's classmates. This helps parents connect with other families at FCCNS and arrange play dates or birthday celebrations. However, we understand that there may be families who prefer that some information not be included for distribution.

Please indicate what information we may share.

_____ all (parent name, address, and phone)
_____ parent name only
_____ address only
_____ phone only
_____ include no information other than my child's name and birthdate
_____ email only

Sunscreen/Lotions Permission

New York State does not allow child care centers to supply sunscreen, lotions, creams, etc. for children in their programs without parental permission. Parents who wish to have a sunscreen, non-prescription lotion, cream or chap stick or lip balm applied to their child must provide said sunscreen, lotion, cream, etc. with their child's name clearly labeled on the original container along with written permission for its application. By checking below, you give FCCNS staff permission to apply to your child the sunscreen, lotion, cream, etc. **you have provided. If sunscreen is not provided by the parents, NYS recommends protective sunscreen clothing be provided by the parents. FCCNS cannot apply sunscreen or lotions not provided by parents.**

_____ non-medicated, PABA-free sunscreen
_____ non-medicated hand lotion
_____ Vaseline or generic equivalent
_____ Desitin ointment or generic equivalent
_____ A&D ointment or generic equivalent
_____ Chapstick or lip balm
_____ other non-medicated lotions, ointments, or sprays supplied by parents

Marketing/Advertising

We take pictures of the children periodically throughout the year and use them for our class journals, projects, on our website and in our monthly newsletter. Sometimes we use pictures in our brochures and flyers as well. We NEVER use a child's name with a photo in any of our uses. Please check below, stating for what you are okay with us using your child's picture. Thank you for helping us show the wonderful things that we do at our center!

I give permission for possible use my child's photo for:

_____ The monthly newsletter
_____ The FCCNS website
_____ The FCCNS Facebook page
_____ Electronic System Communication
_____ Flyers for marketing purposes
_____ Slideshows at the center
_____ Brochures or advertisements (Remember, children's names are never used with any photo)

Child's Name ______________________________

Permission For School-Age Child To Use Wheeled Toys Requiring A Helmet

I give permission for my child to ride any wheeled toys that we send from home for use during child care hours, such as razor scooters, roller blades, skateboards and bikes while attending Faith Child Care and Nursery School. I understand that I am responsible for providing appropriate protective equipment for my child. If we send toys from home, we will also provide the protective equipment. If this protective equipment is not sent, your child will not be allowed to ride their wheeled toy. I understand that if FCCNS deems the protective equipment brought by a child to be inadequate for the activity, he/she will not be permitted to participate. I further understand that any protective equipment that is left on site is done so at my own risk and FCCNS assumes no liability for lost or damaged equipment or for injury to my child resulting from the condition of wheeled toys that are not the property of FCCNS.

Email

In order to save paper we will be distributing many of our important papers via email. It is important that we have a valid email address listed on your emergency card, and that you check that email address weekly.

Signature

My signature below indicates that I have read and understand the above and have marked each item as appropriate. Furthermore, I understand that this information is effective for the period of my child's enrollment at Faith Child Care & Nursery School.

Parent's Signature ______________________________ Date ______________

Parent's Printed Name ______________________________

Subsequent signoffs:

If nothing has changed, please sign below. If there are changes, a new form is required.

Parent's Signature ______________________________ Date ______________

Parent's Signature ______________________________ Date ______________

Parent's Signature ______________________________ Date ______________

Parent's Signature ______________________________ Date ______________

Parent's Signature ______________________________ Date ______________

Parent's Signature ______________________________ Date ______________

FOR OFFICE USE ONLY

	M	T	W	Th	F
PM SNACK	Y__N	Y__N	Y__N	Y__N	Y__N
LUNCH	Y__N	Y__N	Y__N	Y__N	Y__N
BREAKFAST	Y__N	Y__N	Y__N	Y__N	Y__N
~DEPARTURE					
~ARRIVAL					

Child's Full Name: ☐ Male ☐ Female

Child's Home Mailing Address:

Date of Birth:

Home Phone:

Start Date:

Date of Discharge:

Name of Person Applying for Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other

Home ______
Work ______
Cell #1 ______
Cell #2 ______

Email address:

Address of Person Listed Above (if different from child's):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have read the policies regarding administration of medications, fees, transportation and the services provided by the facility, which are found in the Parent Handbook and the Office of Children and Family Services regulations under which it operates. I authorize this facility to release my child to any of the emergency contacts listed on the other side of this document. I agree to review/update this information whenever a change occurs and at least once every six months. I authorize this facility to release medical/health information to the Health Consultant Nurses for the purpose of addressing any health concerns. _____Yes _____No

I give consent for my child to take part in field trips away from the facility with prior notice and under proper supervision and understand that additional permissions regarding transportation, medication and release of information may be needed. _________Yes _____No

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. _____Yes _____No

I have provided information on my child's special needs (allergies, diet, disabilities and/or medical information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. _________Yes _____No

Signature of Parent or Person(s) Legally Responsible:

Date:

FAITH CHILD CARE & NURSERY SCHOOL
2576 Browncroft Blvd., Rochester, NY 14625
(585)385-2360

CC ____ SA ____

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If yes, what is your child allergic to? ☐

Does your child have any special needs/services?
Early Intervention/Special Ed ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy ☐

Child's Source of Medical Care/Primary Care Physician's Name:

Telephone:

Hospital of Choice:

Medical Insurance Provider:

Policy Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY CONTACTS AND PERMISSION TO PICK UP CHILD

RELATIONSHIP	EMERGENCY CONTACT NAME (Please provide four names)	TELEPHONE DURING CHILD CARE	OTHER TELEPHONE
Parent/Guardian 1		Work ☐ Cell ☐	Work ☐ Cell ☐
Parent/Guardian 2		Work ☐ Cell ☐	Work ☐ Cell ☐
		Work ☐ Cell ☐	Work ☐ Cell ☐
		Work ☐ Cell ☐	Work ☐ Cell ☐

LOTION/CREAM LOG

Start Date: ____________ End Date: ____________ Class: Butterflies

CHILD	LOTION																										
Nolan	Corcoran																										
Grayson	Gebhardt																										
Makenzie	Harrington																										
Mia	Ingerson																										
Susan	Lentner																										
Asher	MacDonald																										
Chelsea	McLean																										
Lenora	Miles																										
Jordan	Newell																										
Noah	Roach																										
Josephine	Sadue																										
Gianluca	Valerio																										
Cameron	Wheaton																										
Peyton	Whelehan																										
	time																										
	date																										
	Administered by																										

Special Health Care Plan for a Child with Asthma

Working in collaboration with the child's parent and Health Care Provider, the following health care plan was developed to meet the needs of:

Child's name:	Child's date of birth:
Name of 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 child's health care provider. This should include information completed on the Medical Statement.

Medications at home:
Medications at child care:
Emergency Plan:

Information specific to this child's asthma:
Known Triggers for this child's asthma (circle all that apply):

colds	mold	exercise	tree pollen
dust (dust mites)	strong odors	grass	flowers
excitement	weather changes	animal dander	smoke
foods (specify):			
other (specify):			

Activities for which this child has needed special attention in the past (circle all that apply):

Outdoors	**Indoors**
field trip to see animals	kerosene/wood stove heated rooms
running hard	painting or renovations
gardening	art projects with chalk, glues, painting
jumping in leaves	pet care
outdoors on cold/windy days (recent only)	pesticide application
playing in freshly cut grass	sitting on carpets
other (specify):	other (specify):

Signs & Symptoms this child displays during an asthma episode (circle all that apply):

fatigue	face red, pale or swollen	grunting
breathing faster	wheezing	restlessness
dark circles under eyes	sucking in chest/neck	agitation
persistent coughing	complaints of chest pain/tightness	
gray/blue lips or fingernails	difficulty playing, eating, drinking, talking	
other (specify):		

Child's name:

Staff to care for child and staff training:
Identify the program staff that will care for this child with asthma:

Staff name:	Credentials or professional license information*

Describe any additional training, procedures, or competencies that the staff identified will need to carry out the health care plan as identified by the parent or health care provider. This should include information from the Medical Statement or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

Signature of Authorized Program Representative
I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR, and First Aid certifications or have a license that exempts them from training and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility name:	Facility ID number:	Facility telephone number:
Authorized child care provider name (please print):		Date:
Authorized child care provider signature:		
Parent/Guardian name (please print):		Date:
Parent/Guardian signature:		

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: __________

Allergy to: ______________________

Weight: __________ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ______________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________

Antihistamine Dose: ______________

Other (e.g., inhaler-bronchodilator if wheezing): ______________

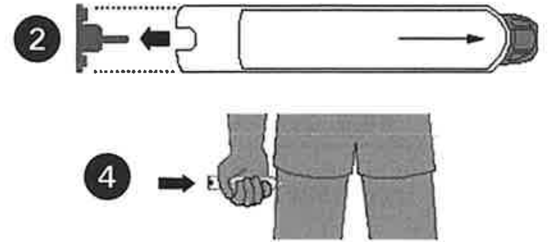
____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Food Allergy Research & Education

EPIPEN® AUTO-INJECTOR DIRECTIONS



1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.

ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014
EMERGENCY CONTACTS — CALL 911
RESCUE SQUAD: ______________________
DOCTOR: ______________________ PHONE: ______________
PARENT/GUARDIAN: ______________________ PHONE: ______________
OTHER EMERGENCY CONTACTS
NAME/RELATIONSHIP: ______________________
PHONE: ______________________
NAME/RELATIONSHIP: ______________________
PHONE: ______________________
Treat the person before calling emergency contacts. The

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ______________

PARENT/GUARDIAN: ______________________ PHONE: ______________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Child's name: ______________________ **Date of plan:** ____________

Date of birth: ___/___/_____ **Age** _____ **Weight:** ________kg

Child has allergy to ______________________________

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): ________________. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): ______________________ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): ______________________ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): ______________________

______________________ __________ ______________________ __________
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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This information should not take the place of talking with your child's doctor.

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: ______________________ **Date of plan:** ______________________

Additional Instructions:

Contacts

Call 911 / Rescue squad: ______________________

Doctor: ______________________ Phone: ______________________

Parent/Guardian: ______________________ Phone: ______________________

Parent/Guardian: ______________________ Phone: ______________________

Other Emergency Contacts

Name/Relationship: ______________________ Phone: ______________________

Name/Relationship: ______________________ Phone: ______________________

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This information should not take the place of talking with your child's doctor.

FAITH CHILD CARE & NURSERY SCHOOL
INCIDENT REPORT

Child's Name: ______________________________ Class: ________________

Date: ____________ Time: ________ Printed name of preparer: ______________

Staff members present when incident occurred: ______________________________

Injury Location			Injury Details		Treatment	
Head	L	R	Bee sting	________	Washed w/soap and water	___
Ear	L	R	Bite	________	Flush with water	___
Forehead	L	R	Blister	________	Ice pack	___
Eye	L	R	Bloody nose	________	Band-aid	___
Cheek	L	R	Bump	________	Tweezers used	___
Nose	L	R	Cut	________	TLC	___
Mouth	L	R	Bruise	________	Other ________________	
Lip Top/Bottom	L	R	Head injury (include head injury guidelines)	________		
Chin	L	R				
Neck	L	R	Pinch	________	**Other**	
Shoulder	L	R	Scrape	________	How/when was parent told?	
Stomach/Abdomen	L	R	Scratch	________	By phone ____ Time ________	
Back	L	R	Sliver	________	This form ____ Time ________	
Arm	L	R	Sunburn	________	Other ______________	
Elbow	L	R	Twist/turn	________		
Wrist	L	R	Other ______________		Where did accident happen?	
Hand	L	R	____________________		Playscape	___
Finger ______________			No visible mark	________	Blacktop/Bikes	___
Leg	L	R	Did child go home as a result of this accident? Yes___ No___		Field	___
Knee	L	R			Classroom	___
Ankle	L	R			Big Room	___
Foot	L	R				
Toe ______________					Other______________	
Other __________	L	R				

Comments/follow-up suggestions:

____
____
____
____
____
____

Staff signature: ______________________________ Date: __________

Parent signature: ______________________________ Date: __________

Rev. 3/2021

White copy to FCCNS
Yellow copy to parent

FCCNS ILLNESS REPORT

Child's Name: ______________________________ Class: ________________

Date: __________ Time: _________ Printed name of preparer: ________________

Dear Parent:

We are sending your child home today because he/she is ill. We have observed the following signs of illness:

_____	Looks sick	_____	Sore throat	_____	Vomiting
_____	Not eating	_____	Rash	_____	Diarrhea
_____	Change in activity level	_____	Red eyes	_____	Stomach ache
_____	Sleeping/very tired	_____	Runny nose	_____	Pain
_____	Fever of _________	_____	Severe cough	_____	Other ___________
_____	Swollen glands	_____	Trouble breathing		

Comments: ____

____

_____ Your child needs more care today than we can safely provide. He/she can return to FCCNS when he/she no longer needs as much care.

_____ Please take your child to the doctor before returning to FCCNS and have the back of this form completed and signed by your physician.

_____ Consult your child's doctor for advice.

Important: In order to contain the spread of illness and to protect all children, **our health policy states that children cannot return to FCCNS until they have gone at least 24 hours without fever or fever-reducing medicine, and no diarrhea or vomiting for 24 hours without a special diet.**

Staff signature: ________________________________ Date: __________

Parent signature: _______________________________ Date: __________

FAITH CHILD CARE & NURSERY SCHOOL
HEALTH STATUS REPORT

Child's Name: ______________________________ Class: ____________________

Date: __________ Time: __________ Printed name of preparer: ____________________

Dear Parent:

We have observed the following signs of illness:

_____ Looks sick	_____ Sore throat	_____ Vomiting
_____ Not eating	_____ Rash	_____ Diarrhea
_____ Change in activity level	_____ Red eyes	_____ Stomach ache
_____ Sleeping/very tired	_____ Runny/stuffy nose	_____ Pain
_____ Fever of ____________	_____ Severe cough	_____ Bloody nose
_____ Swollen glands	_____ Trouble breathing	_____ Headache
	_____ Eye discharge	_____ Other ____________

Comments: ____

____

____

_____ We are sending your child home today because he/she is ill and needs more care than we can safely provide. He/she can return to FCCNS when he/she no longer needs as much care.

_____ Please take your child to the doctor before returning to FCCNS and have the back of this form completed and signed by your physician.

_____ Consult your child's doctor for advice.

Important: In order to contain the spread of illness and to protect all children, our health policy states that **children cannot return to FCCNS until they have gone at least 24 hours without fever or fever-reducing medicine, and no diarrhea or vomiting for 24 hours without a special diet.**

Staff signature: ______________________________ Date: ____________

Parent signature: ______________________________ Date: ____________

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White copy to FCCNS
Yellow copy to parent

Date: ____________________

________________________ was examined in our office today. He/she has the following
(Child's name)

diagnosis: ____

____.

He/she will be free of contagion and safe to return to group care on ____________________.
(Date child may return)

Does this diagnosis require medication? Yes No

If yes, please provide type of medication: __________________________________

If medication is to be given during the time that he/she is at Faith Child Care & Nursery School please complete the appropriate forms.

Signed: ________________________________
(Physician's signature)

____
(Physician's printed name)

White copy to FCCNS
Yellow copy to parent

Immunization Policy

POLICY:

The Daycare Administrative Staff will be knowledgeable regarding the immunization requirements of Public Health Law (PHL) Section 2164

PURPOSE:

- To uphold and enforce the provisions of PHL Section 2164
- Each day care/preschool will maintain a current and complete list of students who are susceptible to vaccine preventable disease(s) so they may be rapidly identified in the event of an outbreak.

REFERENCES:

Public Health Law Title VI Poliomyelitis and Other Disease
School Immunization Requirement Public Health Law Section 2164 Rules and Regulations Subpart 66-1
New York Daycare Center Licensing Requirements Part 418-1
http://www.daycare.com/newyork/new-york-daycare-center-licensing-requirements.html#s11

DEFINITIONS:

Susceptible Children are those that:

- Have not submitted an immunization record
- Have been granted a religious or medical exemption
- Are " in process" of being immunized
- Have not received adequate or valid doses of the required vaccines
- Have not provided an "acceptable proof of immunity"

In process Children are those that:

- Have received initial doses of required vaccine(s) and has an appointment for subsequent dose(s) OR
- Have an appointment to receive initial dose(s) of vaccines within an applicable 14 or 30 day grace period.

Acceptable proof of Immunity is defined as:

- A valid immunization record of all age appropriate vaccines OR
- Results of valid and acceptable serologic tests (measles, mumps, rubella, varicella, hepatitis B and polio) OR
- A valid medical diagnosis by a physician, physician assistant or nurse practitioner as having had a history of varicella disease.

Valid Immunization Record must be signed or stamped by a health care provider and is defined as:

- A certificate from a health care provider
- Immunization registry record
- Cumulative health record from a previous school
- Migrant health record
- Immunization transfer record
- Military immunization record
- Immunization portion of a passport
- An immunization record card signed by a health care provider
- An immunization record may also show health care provider diagnosis of disease or laboratory evidence of immunity.

PROCEDURE

Obtaining Documentation:

- The agency will maintain a record of disease immunity and/or valid exemptions for diseases in accordance to PHL 2164 New York State Immunization Requirements for School Entrance/Attendance for each enrollee (see attached sample).
- The agency will request a valid immunization record of all children upon entry to the center within 14 days. Children coming from out of state or out of country who show a good faith effort to comply with immunization requirements may be granted 30 days to supply such proof.
- The agency may accept valid medical and / or religious exemptions documentation in lieu of proof of immunization. These documents will be reviewed to determine if they meet the requirements of PHL. It is the right and responsibility of the day care/preschool to accept or reject a medical or religious exemption (see attached samples and NYSDOH guidance letter).
    - **Medical exemptions** will at a minimum note the vaccine for which the exemption was written, the child's precaution/contraindication to vaccination, and the expiration date of the exemption. The medical exemption should be signed and dated by a New York State licensed physician.
    - **Religious exemptions** are a statement or form signed by the parent or guardian of a child that indicates the child has not received any or all immunizations due to their genuine and sincere religious beliefs is proof of a religious exemption. Personal religious beliefs may be separate from religious affiliations.

Tracking "In-Process" Children:

- At minimum monthly, the agency will track all children who are "in-process" of receiving immunizations.
- The agency will create a paper or electronic tracking system that includes the child's name, date of birth, and if the child is in process of receiving immunizations, has a valid medical exemption, or has a valid religious exemption (see attached sample).

- The agency will provide a reminder to parents of upcoming immunization requirements.
- The Health Advocate for Faith Child Care and Nursery School tracks each child's immunizations monthly and makes note as to which children are "in-process" and which children are exempt. Families are notified if they are behind on vaccinations or physicals for their child.

List of Susceptible Children

- The agency will develop a list of children who are susceptible to vaccine preventable disease(s) so they may be rapidly identified in the event of an outbreak (see attached sample).
- The list will be updated as "in-process" children become fully vaccinated against each vaccine preventable disease.
- Religious and / or medically exempt children may remain on the susceptible list indefinitely.
- The list will be accessible to agency administrative staff and will be shared with the local health department in the event of an outbreak.

Enforcement of Immunization Requirements:

- Public Health Law requires day cares/preschools to exclude children who are not in compliance with required immunizations by age.
- Children who are noncompliant are those for whom the day care/preschool has not received:
    - A valid immunization record,
    - Other acceptable proof of immunity (diagnosis of disease or serological evidence of immunity to the diseases specified in the NYCRR 66-1),
    - A valid religious or medical exemption,
    - A child/children being "in process" of receiving their immunizations.

- For children who are non-compliant the agency will:
    - If your child is behind on immunizations/physical forms, you will be notified with a reminder that we need updated forms from your child's physician. If your child's medical forms lapse by 30 days, you will be given a notice to bring the forms to our office by a specified date or your child will not be allowed to come to back to our program until the correct forms are completed and returned to us.

Agency staff will consult with the local health department as needed for assistance in obtaining immunization records.

Anaphylaxis Policy

In compliance with NYS Day Care Centers (DCC) regulations, sections 418-1.11 (c) (2)(x), (e)(4), (h)(5), (h)(6), and (h)(8)(i), and NY Public Health Law Section 2500, Health Care Plans, and staff training, FCCNS is required to and has at least one trained staff member in the prevention, recognition and response to food and other allergic reactions and anaphylaxis. This includes but is not limited to the use of epinephrine auto-injectors, Diphenhydramine, when prescribed in combination with the auto-injector, asthma inhalers and asthma nebulizers when necessary to prevent anaphylaxis or breathing difficulty.