HEALTH CARE PROGRAM – CHILD CARING INSTITUTIONS, PRIVATE SECURE FACILITIES, GROUP HOMES, AND EMERGENCY SHELTERS

State Form 45879 (R4 / 4-20)

INDIANA DEPARTMENT OF CHILD SERVICES
CHILD WELFARE SERVICES – MS 47
302 West Washington Street, Room E306
Indianapolis, IN 46204-2739

INSTRUCTIONS: *For sections 3 through 12, check Yes for each item if it is a statement of the practice at your facility.*
Check No if the statement does not agree with your practice.
If you check No, please attach documentation explaining why, and what the practice of your facility is regarding the specific statement.

FOR ALL FACILITY TYPES, the following items must be attached to the Health Care Program review:

1. *First Aid directives and supplies with consulting physician/nurse practitioner's original signature and date*
2. *Order for over the counter / as needed medications with consulting physician/nurse practitioner's original signature and date*
3. *Copy of the facility's employees' health examination form*
4. *Copy of the facility's record form used to record physician's monthly report of psychotropic medications*
5. *Copy of the facility's children dental examination form*
6. *Copy of the facility's children health examination form*
7. *Copy of the facility's children health assessment form (Emergency Shelters only)*

Name of facility	Facility number	Date *(month, day, year)*
Address *(number and street, city, state, and ZIP code)*		County
Mailing address *(if different from above)*		
Facility is licensed as: *(Check one.)* ☐ Institution ☐ Private Secure Facility ☐ Group Home ☐ Emergency Shelter Institution ☐ Emergency Shelter Group Home		
Number of children licensed for	Ages licensed for	Gender(s) of census
Name of administrator		
Name of person completing form	Title of person completing form	
Contact telephone number of person completing form ( )	E-mail address of person completing form	

SECTION 1 – HEALTH PROGRAM

Arrangements have been made for the consulting physician or nurse practitioner below to review and revise the written health program attached. Their signature below indicates their consent to participate in the health program review.		☐ Yes ☐ No
Name of physician (MD or DO) / nurse practitioner	License number	Contact telephone number ( )
Original signature of consulting physician / nurse practitioner		Date signed *(month, day, year)*

SECTION 2 – EMERGENCY CARE OF CHILDREN

The nearest emergency medical facility who will provide medical examinations and care of children upon illness or in an emergency situation is:

Name of medical facility	Hours of operation	Contact telephone number ( )
Address of medical facility *(number and street, city, state, and ZIP code)*		

SECTION 3 – EMPLOYEE HEALTH PROGRAM

A.	Within thirty (30) days of employment, each staff member will have a health examination.	☐ Yes ☐ No
B.	Within thirty (30) days of employment, and annually thereafter, each staff member will have a Mantoux tuberculin skin test.	☐ Yes ☐ No
C.	Volunteers having direct contact with children meet the same health examination requirements as paid staff.	☐ Yes ☐ No
D.	Facility does not permit employees who become ill or who return to work following an illness, to work in a capacity which may transmit disease or be detrimental to the health of children or other employees.	☐ Yes ☐ No

SECTION 4 – CONTROL OF PETS

A.	Pets will be kept in the home. *(If No, skip to the next section.)*	☐ Yes ☐ No
B.	If yes, what type of animals?	Number of animals
C.	Pets kept in the home have been immunized against rabies, if indicated.	☐ Yes ☐ No

SECTION 5 – PROTECTION IN THE EVENT OF A DISASTER	
A. Disaster evacuation procedures in case of fire and other emergencies are posted in an easily visible area in all living units.	☐ Yes ☐ No

SECTION 6 – FIRST AID AND EMERGENCIES	
A. Each direct childcare worker is trained to give first aid upon employment.	☐ Yes ☐ No
B. The Red Cross Manual of First Aid is available for ready use, or the equivalent manual is available.	☐ Yes ☐ No
If using equivalent manual, please specify.	
C. Where are first aid supplies located?	
D. First Aid directives address directions for the treatment of hemorrhaging, choking, seizures, poisoning, and artificial respiration.	☐ Yes ☐ No
E. First Aid directives are readily available and posted in an easily visible area.	☐ Yes ☐ No
F. Where are first aid directives posted?	
G. Is a staff person trained in CPR present at all times the facility is open?	☐ Yes ☐ No
H. Staff are trained in Universal Precautions upon employment and annually thereafter. Verification of training is documented in the employee's record.	☐ Yes ☐ No
I. Universal Precautions supplies are readily available to staff.	☐ Yes ☐ No
J. Where are the universal precautions supplies located?	
K. A telephone and telephone numbers are immediately available for consulting physician / nurse practitioner, nearest emergency facility, ambulance services, local fire department, poison control center, and consulting dentist.	☐ Yes ☐ No
L. Placing agency, parents or guardians will be notified of accidents, injuries or serious illness, and if a child requires medical or surgical care.	☐ Yes ☐ No
M. A written placement agreement has been established to give child caring facility permission to seek routine and emergency medical, surgical, and hospital care for the child.	☐ Yes ☐ No

SECTION 7 – MEDICATION	
A. Special medical procedures and the giving of medications for any child in the facility shall be done only on the written order / prescription from the prescriber.	☐ Yes ☐ No
B. Individual prescriptions shall be kept in original pharmacy containers.	☐ Yes ☐ No
C. The original pharmacy label showing the prescription number, date filled, prescriber's name, child's name, and directions for use shall be maintained.	☐ Yes ☐ No
D. Non-refrigerated medication will be stored in a locked cabinet, box, or drawer outside the kitchen area, and stored in a safe place, not accessible to children.	☐ Yes ☐ No
E. Location of locked medications	
F. Medications requiring refrigeration are store in a plastic, covered container label medications, and stored in a safe place, not accessible to children.	☐ Yes ☐ No
G. Location of medications requiring refrigeration	
H. Accurate individual child records showing the date and time medication is given, why it is given, how much is given, and by whom the medication was administered shall be kept of all medications and treatments.	☐ Yes ☐ No
I. Unused portions of any child's prescription, narcotic, and expired medications shall be disposed of as follows: ☐ Destroyed immediately ☐ Returned to the pharmacy ☐ Other	
If Destroyed or Other, please describe.	
J. Consulting physician / nurse practitioner's written orders for as needed or over-the-counter medications are posted where such medications are stored.	☐ Yes ☐ No
K. A written report from the prescriber every thirty (30) days on every child receiving psychotropic medication is kept in the child's health record.	☐ Yes ☐ No
L. A child receiving psychotropic medication is seen every ninety (90) days by the prescriber of the psychotropic medication.	☐ Yes ☐ No

SECTION 8 – TRANSFER OF CHILD'S HEALTH RECORDS ON DISCHARGE	
A. A summary will be written regarding health recommendations for the child and will be available to the parents, guardians, or other individuals and agencies charged with responsibility for the health care of the child when child is discharged from this facility.	☐ Yes ☐ No

SECTION 9 – DENTAL CARE		
A. Arrangements have been made for the services of a dentist to supervise and maintain an adequate program of dental examination and dental care of children.		☐ Yes ☐ No
Name of dentist	License number	Contact telephone number ( )
Address dentist *(number and street, city, state, and ZIP code)*		

If your facility is licensed for, or intends to be licensed as, an **Emergency Shelter only, *skip to section 12***.
If your facility is licensed for, or intends to be licensed as, a **both a Long Term and an Emergency Shelter, *you must complete all remaining sections.***

SECTION 10 – DENTAL EXAMINATIONS		
A.	Each child will be given a dental examination and required treatment within ninety (90) days of admission, every six (6) months, and when needed.	☐ Yes ☐ No

SECTION 11 – CHILDREN'S HEALTH EXAMINATION AND IMMUNIZATIONS		
A.	Upon admission, arrangements have been made for each child to receive a health examination by a physician / nurse practitioner and any treatment and corrective measures for physical defects recommended by the physician / nurse practitioner will be provided or arranged for.	☐ Yes ☐ No
B.	For each child, provision has been made for the health examination to include a health history.	☐ Yes ☐ No
C.	For each child, provision has been made for the health examination to include a physical examination within two (2) weeks of admission.	☐ Yes ☐ No
D.	For each child, provision has been made for the health examination to include a vision and hearing screening.	☐ Yes ☐ No
E.	For each child, provision has been made for the health examination to include a Mantoux test for tuberculosis within two (2) weeks of admission and annually thereafter. If a test is positive, diagnostic chest X-Ray and other indicated laboratory tests to determine infectious state will be performed.	☐ Yes ☐ No
F.	The statement of medical findings in the health examination will include physical defects.	☐ Yes ☐ No
G.	The statement of medical findings in the health examination will include a statement regarding development.	☐ Yes ☐ No
H.	The statement of medical findings in the health examination will include the need for any dental care.	☐ Yes ☐ No
I.	The statement of medical findings in the health examination will include the presence or absence of communicable disease.	☐ Yes ☐ No
J.	The statement of medical findings in the health examination will include the ability of the child to take part in group activities.	☐ Yes ☐ No
K.	Arrangements have been made for health examinations (the same as required on admission) to be conducted annually and whenever the child's condition indicates the need to be evaluated.	☐ Yes ☐ No
L.	Upon admission, a statement will be provided as to whether or not the child has been exposed to a communicable disease within the previous three (3) weeks.	☐ Yes ☐ No
M.	Arrangements have been made for an immunization and booster injection program to include the immunizations required by the Indiana State Department of Health.	☐ Yes ☐ No
N.	If records of immunizations cannot be obtained within thirty (30) days of admission, the immunization series will be started, following the Indiana State Department of Health's recommended time schedule.	☐ Yes ☐ No
O.	Will children of resident staff reside on the facility premises? *(If no, you may move to the next section.)*	☐ Yes ☐ No
P.	Children of resident staff will have complete immunization records.	☐ Yes ☐ No

SECTION 12 – CHILDREN'S HEALTH EVALUATION AND IMMUNIZATIONS *(To be completed by Emergency Shelters only.)*		
A.	Upon admission, the health evaluation checklist, State Form 49965, is utilized to determine obvious health problems of the child.	☐ Yes ☐ No
B.	Any child suspected of physical or sexual abuse, and who has not received medical treatment will receive a physical examination immediately.	☐ Yes ☐ No
C.	Any child suspected of having a communicable disease or chronic disease that needs constant therapy will receive a physical examination by a licensed physician or nurse practitioner within forty-eight (48) hours of admission.	☐ Yes ☐ No
D.	All other children will have a physical examination and communicable disease determination by a licensed physician or nurse practitioner three (3) months prior to placement or within thirty (30) days after placement.	☐ Yes ☐ No
E.	The facility will obtain all available health records including immunization history within seventy-two (72) hours or on the next work day of admission.	☐ Yes ☐ No
F.	Will children of resident staff reside on the facility premises? *(If no, you may move to the next section.)*	☐ Yes ☐ No
G.	Children of resident staff will have complete immunization records.	☐ Yes ☐ No

SECTION 13 – APPROVAL AND UNDERSTANDING	
The above information and attached documentation are correct, accurate, and serve as a written commitment to follow the content and practices referred to within our facility's Health Care Program.	
Original signature	Date signed *(month, day, year)*
Printed name	Title ☐ Owner ☐ President ☐ Board of Directors ☐ Administrator