HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
State Form 45877 (R9 / 7-19)

IF THIS IS A PROPOSED (NEW SITE OR NEW OWNER) FACILITY, YOU MUST SUBMIT AN APPLICATION FOR LICENSURE PRIOR TO SUBMITTING THIS PROGRAM.

Instruction for completion: Health Programs

Health Program forms are to be used by Child Care Centers for the purpose of reporting the development of their written health program in compliance with the regulations for licensure. The health program must be completed in and approved prior to licensure or if there are any changes to the license that is listed under 470 IAC 3-4.7-84(c). The form incorporates the requirements of 470 IAC 3-4.7.84.

All items in the forms must be carefully studied and completed by the authorities responsible for the development of the health program. A number of attachments, which are identified in the health program forms, are required. The programs will be reviewed to determine compliance with licensing requirements.

The original completed forms and one (1) original set of attachments must be submitted to the Family and Social Services Administration, 402 West Washington Street, Room W362, Indianapolis, IN 46204.

If the health program is not in substantial compliance with regulations, both forms and attachments will be returned to the facility for corrections and resubmittal.

STATEMENT OR EXPLANATION REGARDING HEALTH CARE CONSULTANT ACTIVITIES

The health care consultant's responsibilities are to assist the Administrator or Director in developing the health policies and procedures and be available for telephone consultation as needed. The consultant may be an MD, DO, or NP with community, family, or pediatric experience or an RN or PA with five (5) years of pediatric experience.

The health care consultant’s liability is limited only to advice they may render.

The rendering of direct care by the health care consultant is not required by Regulations.

It is expected that all children in child care centers will continue to receive direct medical care from their family physician or clinic.

If the “First Aid Supply List” or the “Skin Care Procedure” contains any medications, including oral and topical over-the-counter items, only a health care consultant with independent prescriptive authority (MD, DO, NP) can authorize these forms.

Over

HEALTH PROGRAM HELPS

Experiences with health programs indicate the most frequent reasons for not approving submitted health programs are:

1. The lack of the health care consultant's **ORIGINAL** signature and date on the first page.

2. The lack of the health care consultant's **ORIGINAL** signature and date on the written first aid directives.

3. The lack of the health care consultant's **ORIGINAL** signature and date on the first aid supply list if the list contains any type of medications *(e.g. Mercurochrome, Bactine, Ointment, etc.).* Your physician must indicate in writing on the list why you are to give it, how often, how much and the date and sign the list. The signature of the MD, DO, or NP on the separate list constitutes a "written order".

   If first aid supplies consist of only soap, water, band-aids, sunscreen, and insect repellent, just indicating it in the health program is adequate; no signature from an MD, DO, or NP is required.

4. A sample of the form used for the children's health examination must be submitted. The form must include all of 470 IAC 3-4.7-86 requirements. (*A recommended health form is attached.*)

5. A sample of the form used for employees' and volunteers' health examination must be submitted. The form must include all of 470 IAC 3-4.7-85 requirements. (*A recommended health form is attached.*)

6. All adults counted in the child-staff ratio must have basic first aid training within three (3) months of employment. All adults counted in the child-staff ratio for infants or toddlers must have basic first aid training prior to giving care.

7. All medications must be in a locked container and inaccessible to children. The only exceptions are those medications requiring refrigeration as indicated on the prescription label. Medications not requiring refrigeration are not to be kept in the kitchen or bathrooms.

8. There are only two (2) types of medications which may legally be given by the child care employee: those medications in a prescription container specifically ordered by the healthcare provider for the individual child, and those medications for which you have a written order from the healthcare provider for the individual child. This includes over-the-counter oral and topical items.

9. If providing care for children under two (2) years of age, the Supplement Health Programs for Infant/Toddler care must also be submitted.

10. One (1) copy of each of the required forms or policies must be attached to each health program.

The following have been included for your use:
1. Recommended Child Day Care Center Health Record form.
2. Recommended Adult Physician Examination Health Record form.
3. Suggested First Aid Directives (*must be approved and signed by your health consultant*).
4. Suggested Skin Care Procedures (*must be completed, approved and signed by your health consultant*).
5. Suggested First Aid Supply form
6. Medication Order form

Return completed forms to:

MS02
Family and Social Services Administration
402 W. Washington St., Rm. W362
Indianapolis, IN 46204

Reset Form

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS

State Form 45877 (R9 / 7-19)

			Date *(month, day, year)*
Name of child care facility			
Location			County
City		ZIP code	Telephone number *(with Area Code)* ( )
E-mail address			
Mailing address *(if different from above)*			
Name of Director		Name of Owner	
Number of children licensed for	Ages licensed for		Hours of operation From: To:

SECTION 1 470 IAC 3-4.1-11 - HEALTH PROGRAM

Definite and specific arrangements have been made for a healthcare provider to provide consultation and help maintain an adequate health program. The medical consultation will be provided by:

Name of health consultant *(print or type)*	License number	Telephone number *(with Area Code)* ( )

This physician / nurse practitioner has consented to serve as the consulting health consultant.

Original Signature of Consulting Healthcare Provider	Date signed *(month, day, year)*

Arrangements have been made by the facility and the consulting health consultant to establish, maintain and review the health program every two years. ☐ Yes ☐ No

This health program is for a proposed facility. ☐ Yes ☐ No

This facility's health program has had past approval. ☐ Yes ☐ No

The position of the person who is designated to be in charge in the absence of the director, has knowledge of all regulations and is to communicate with state personnel is: _____.
Name of position

An agreement has been established with the hospital which is located closest to the facility for the emergency admission of a child who has a life threatening illness or injury.

Name of hospital

Address of hospital (*number and street, city, state, and ZIP code*)

SECTION 2 470 IAC 3-4.1-12 - PRE-ADMISSION HEALTH PROCEDURES

Health Examination - Children

A health examination by an MD, DO, NP, or PA is required for each child within three (3) months prior to admission, but no later than one (1) month after admission; and the examination includes the following:

1. ☐ Yes ☐ No Health history
2. ☐ Yes ☐ No Physical examination and progress in development, signed by child's healthcare provider
3. ☐ Yes ☐ No Written statement by healthcare provider or parent of immunization history
4. ☐ Yes ☐ No Exceptions to any of the required immunizations will be permitted only with healthcae provider written certification.
5. ☐ Yes ☐ No A written statement by a healthcae provider that in the opinion of the healthcae provider the child does not have a health condition that would be hazardous either to the child or to other children in the day nursery if this child participated in the nursery's program of activities

   ATTACH A COPY OF THE FORM USED FOR THE CHILD'S HEALTH EXAMINATION.
6. ☐ Yes ☐ No There will be a written statement by the healthcae provider regarding modifications needed in the care of children who may require special attention because of medical conditions *(e.g., convulsive disorders, hyperactivity, etc.)*
7. ☐ Yes ☐ No The child will be excluded if any of the above requirements are not met

ATTACH A COPY OF THE FORM USED FOR THE CHILD'S HEALTH EXAMINATION.

Periodic Health Examination

Periodic health examinations will be required as follows:

8. ☐ Yes ☐ No Annually for children two (2) years of age and younger.
9. ☐ Yes ☐ No More frequently if the child's general condition indicates.
10 ☐ Yes ☐ No When the child has a condition which is potentially hazardous to others.
11. ☐ Yes ☐ No If a child frequently requires separation from the group and special observation for fatigue, illness or emotional upset, a report will be available to parents or guardians; and they will be asked to take the child to an MD, DO, or NP for evaluation.

SECTION 3 470 IAC 3-4.1-7 (e)(2) - CHILD'S HEALTH RECORD

Health and medical records are current, on file in the licensed facility for each child and contain the following information:

12. ☐ Yes ☐ No The prescriber's written instructions regarding any special dietary or other special health care the child may need.

13 ☐ Yes ☐ No A record of all the medications and first aid given the child in the facility.
14. ☐ Yes ☐ No The record includes:
   a. ☐ Yes ☐ No Prescription number or name of medication, amount, time and date given, name of prescriber and person who gave the medication.
   b ☐ Yes ☐ No Description of injury, date and time of first aid treatment and who gave the treatment.
   c. ☐ Yes ☐ No That parents were notified of all accidents.
15. ☐ Yes ☐ No Record of absences due to illness or injury.

SECTION 4 470 IAC 3-4.1-8 - HEALTH EXAMINATIONS FOR PERSONS PERFORMING SERVICES

16. ☐ Yes ☐ No Children are excluded if physical exam and immunizations are not documented within 30 days.
17. ☐ Yes ☐ No Employees will have a complete physical during the period 12 months prior to, or within 30 days, of employment.
18. ☐ Yes ☐ No Mantoux tuberculin skin test, or equivalent screening approved by the ISDH, date and results of the test.
19 ☐ Yes ☐ No Diagnostic chest X-ray if Mantoux test is positive.
20. ☐ Yes ☐ No No person will be allowed to perform any services in the nursery until above is completed.

ATTACH A COPY OF THE FORM USED FOR THE EMPLOYEES' HEALTH EXAMINATION. IT MUST PROVIDE AN AREA TO RECORD RESULTS OF MANTOUX TUBERCULIN TEST, HEALTH HISTORY, ALLERGIES AND CHRONIC HEALTH CONDITIONS.

21 ☐ Yes ☐ No Volunteers, substitutes, student aides and any other personnel having direct contact with the children or providing food service will have the same kind of examination as the employees.
22. ☐ Yes ☐ No Annual Mantoux tuberculin skin tests, or equivalent screening approved by the ISDH, shall be required of all adults having direct contact with children, including food service personnel.

SECTION 5 470 IAC 3-4.1-11(a)(b) - CONTROL OF COMMUNICABLE DISEASES

23. ☐ Yes ☐ No Staff members and other persons with an illness shall not be permitted to have contact with children nor be permitted to work in a capacity where illness could be transmitted. Ill staff are excluded.
24. ☐ Yes ☐ No Children who are ill upon arrival to the facility shall not be admitted.
25. ☐ Yes ☐ No Children who become ill while in attendance will be isolated, kept under direct supervision and parents notified to take the child home.
26. ☐ Yes ☐ No The isolation room is not used for any other purpose by children while being used as isolation quarters.
27 ☐ Yes ☐ No The cot(s) and other furnishings of the isolation room can be easily sanitized.
28. ☐ Yes ☐ No Toilet and lavatory facilities are located within or near the isolation room

Where is the isolation room located? _____

_____

29. ☐ Yes ☐ No Arrangements have been made to consult a medical practitioner or the local health officer for instructions regarding control measures when exposure to a disease has occurred in the child care center.

These measures include the following:

a ☐ Yes ☐ No Disinfection of toilet facilities, furnishings and toys or other articles used by the ill child.
b ☐ Yes ☐ No Proper disposal of body discharges.
c. ☐ Yes ☐ No The cot, facilities or articles that have been used by a child suspected of having a communicable disease, will not be used by any other person until properly disinfected or until it is established the child did not have a communicable disease.

SECTION 5 **470 IAC 3-4.1-11(a)(b) - CONTROL OF COMMUNICABLE DISEASES *(continued)***

30. ☐ Yes ☐ No Arrangements have been made to notify all parents and staff members when a child is known to have a communicable disease.

31. ☐ Yes ☐ No Before readmission, the child care staff members will ascertain that the child does not have a condition which would prevent participation in center activities.

32 ☐ Yes ☐ No If pets are kept, they will be nonvicious, free from disease and shall be immunized against rabies, if indicated.

33. ☐ Yes ☐ No Animals will be housed in such a manner which prevents injury either to the children or the animals. Ferrets, turtles, reptiles, psittacine birds, or any wild animals will be prohibited.

SECTION 6 **470 IAC 3-4.1-11(c) - CARE OF ILLNESS AND INJURY**

ATTACH A COPY OF THE HEALTH CONSULTANT'S WRITTEN DIRECTIVES WHICH THE HEALTH CONSULTANT HAS SIGNED AND DATED REGARDING FIRST AID TO BE GIVEN AT THE CENTER

There must be directives for the treatment of hemorrhaging, choking, seizures, poisoning, artificial respiration. *(If licensed for children under 2 years of age, include directives for the treatment for shock in that age group)*

34 ☐ Yes ☐ No First aid directives are posted in every room occupied by children.

35. ☐ Yes ☐ No First aid policies provide for:

a. ☐ Yes ☐ No All persons counted in the child/staff ratio to have training in basic first aid within three (3) months of providing care and a refresher course every two (2) years thereafter. *(Infant and toddler staff must be trained upon employment)*

b. ☐ Yes ☐ No A telephone is provided within the facility and immediately available telephone numbers that include consulting medical provider, nearest emergency facility, ambulance service, local fire department, dentist and poison control.

It is recommended that an individual emergency card be kept for each child. The card should include the parent(s) name and telephone number, name and telephone number of a responsible person to call if the parent(s) cannot be reached as well as the child's allergies, doctor, hospital preference and a brief medical history.

36. ☐ Yes ☐ No The Red Cross First Aid Manual or its equivalent is available.

a. Give title: _____

b. List the first aid supplies the consulting medical provider has indicated you are to have on hand. _____

_____

_____

c. If any medications such as acetaminophen, ointment, etc., are included in the first aid supplies, the consulting MD, DO, or NP original signature and date must be on the list, as well as why you should give the medication, how much, and how frequently.

d. Where do you keep the first aid supplies? _____

SECTION 7 **470 IAC 3-4.1-11(2)(d) - MEDICATION**

37. ☐ Yes ☐ No The health policies include the giving or the application of medication, providing dietary supplements, making special variations in diets and carrying out special medical procedures for any child and will be done only on the written order or prescription from a prescriber.

Individual prescriptions:

a ☐ Yes ☐ No Are kept in the original containers.

b. ☐ Yes ☐ No Have the original pharmacy label showing prescription number or name of medication, date filled, prescriber's name, child's name and directions for use *(frequency and amount to be given).*

38. ☐ Yes ☐ No Over-the-counter medications or sample medications have a prescriber's written order indicating child's name, name of medication, reason for giving, frequency of use, dosage to be given. *(The prescriber's original signature and date must appear on the written order.)*

39. ☐ Yes ☐ No All medications will be kept in a locked cabinet, drawer or box.

Where is the locked cabinet, drawer or box for non-refrigerated medications located?

(This location is not to be in the kitchen or bathroom.) _____

SECTION 7 **470 IAC 3-4.1-11(2)(d) - MEDICATION *(continued)***

40. ☐ Yes ☐ No Medication requiring refrigeration will be stored in a lidded, plastic container, marked "medication".

41 ☐ Yes ☐ No All medication given in the facility will be recorded when medication is given and by whom it is administered.

42. ☐ Yes ☐ No Unused portions of any child's prescription will be returned to the child's family.

SECTION 8 **470 IAC 3-4.1-11(2)(e) - PERSONAL HYGIENE**

43. ☐ Yes ☐ No The facility's schedule provides for supervised washing of hands and face before meals and after using the toilet.

44. ☐ Yes ☐ No Soap is provided at every handwashing sink.

45. ☐ Yes ☐ No Disposable towels are used and are provided in a dispenser at every handwashing sink.

46. ☐ Yes ☐ No Toilet paper is provided in a dispenser at every toilet.

47. ☐ Yes ☐ No If toothbrushes are used, they are stored separately from one another and in a sanitary manner.

SECTION 9 **470 IAC 3-4.1-11(2) - GENERAL SAFETY**

48 ☐ Yes ☐ No All equipment, materials and furnishings whether for indoor or outdoor use, are sturdy, clean and in a safe condition.

49. ☐ Yes ☐ No All cleaning supplies and hazardous articles (labeled “Keep Away from Children” or “Keep out of Reach of Children”) are inaccessible to children.

50. ☐ Yes ☐ No All poisons, chemicals and items labeled "Fatal if Swallowed" are in locked storage.

SECTION 10 **470 IAC 3-4.1-15 - DISASTER SAFETY**

51. ☐ Yes ☐ No Written, posted procedures for disaster evacuations and shelter within the buildings are posted in all child care areas.

SECTION 11 **470 IAC 3-4.1-14(a) - SPACE**

52. ☐ Yes ☐ No Clothes-hanging hooks are provided for each child and are spaced far enough apart so that one child's clothing does not touch that of another child. *(Hats and collars, hoods and shoulder area of coats must not touch)*

SECTION 12 **470 IAC 3-4.1-10(2) - PHYSICAL CARE**

53. ☐ Yes ☐ No Supervised nap periods are provided for preschool children after the noon meal.

54. ☐ Yes ☐ No A firm, portable, narrow, easily-sanitized cot, whose sleeping surface is off the floor, is provided for each preschool child.

55. ☐ Yes ☐ No Cots are maintained in a good state of repair.

56. ☐ Yes ☐ No Cots are spaced two (2) feet apart on all sides.

57. ☐ Yes ☐ No Children lie in such a way that direct face-to-face positions are avoided.

a. The majority of cots that the facility uses are: *(regular canvas, vinyl, plastic, water-proofed canvas)*

_____

b. The majority are sanitized by the following method: *(Include chemical and concentration.)*

_____

(Regular canvas coverings are taken off the frame and washed in bleach and warm water in a clothes washer for twenty-five (25) minutes.)

58 ☐ Yes ☐ No A different child uses a different cot each day.

59. ☐ Yes ☐ No The same child uses the same cot each day.

a. How frequently are cots sanitized? _____

Each child's blanket is stored:

b. ☐ Yes ☐ No On individually marked cot

c. ☐ Yes ☐ No In individually marked cubicle

d. ☐ Yes ☐ No In individually marked sack

SECTION 13 **470 IAC 3-4.1-7(d) - SMOKING**

60. ☐ Yes ☐ No Smoking is prohibited in the kitchen, in the presence of children and in areas which will be occupied by children.

SECTION 14 **470 IAC 3-4.1-9-2(c) - TWO (2) YEAR OLDS AND ABOVE WHO ARE NOT TOILET TRAINED**

61. ☐ Yes ☐ No We accept two (2) year old and older children who are in diapers or pull-ups.
The diaper changing table consists of:
a. ☐ Yes ☐ No Soft washable *(plastic covered)* pad
b ☐ Yes ☐ No A sanitizable table
c. ☐ Yes ☐ No Clean waterproof, disposable paper which covers the entire pad and is discarded after each use.

62. ☐ Yes ☐ No The diaper changing pad is sanitized when it becomes soiled and at the end of the day.

If no changing table / cot is used, omit items 61 and 62; answer items 63 through 67.

63 ☐ Yes ☐ No Time of bowel movements is entered on a daily chart.

64. ☐ Yes ☐ No The consulting physician has approved a skin cleansing procedure.

ATTACH A COPY OF THE SKIN CLEANSING PROCEDURE THAT CONTAINS THE HEALTH CARE CONSULTANT'S ORIGINAL SIGNATURE AND DATE.

65. ☐ Yes ☐ No Caregivers wash their hands before and after diapering children.

66 ☐ Yes ☐ No Soiled diapers / pull-ups shall be kept in a plastic bag in a tightly covered, sanitary container that is inaccessible to children.

67. ☐ Yes ☐ No A supply of diapers / pull-ups shall be available at all times, stored off the floor, and inaccessible to children.

HAVE YOU ATTACHED ONE (1) COPY OF THE FOLLOWING TO EACH PROGRAM?

The form used for the child's health examination.

The current recommended first aid directives for the care of ill or injured children that have been signed and dated by the health care consultant. <u>These procedures must itemize the care for seizures, choking, hemorrhage, poisoning and artificial respiration</u> *(and shock if licensed for children under two (2) years of age)*.

The form used for the employee health examination.

Health care consultant's signed and dated skin cleansing procedures for diapered two (2) year olds.

Signature of: *(check one)* ☐ Owner ☐ President of Board of Directors ☐ Director	Date signed *(month, day, year)*

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
PROCEDURE FOR SKIN CARE - DIAPERING

State Form 49971 (R4 / 7-19)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W362
INDIANAPOLIS, IN 46204

Objective: To cleanse baby's skin after urination and / or bowel movement.

To insure comfort to baby.

To prevent diaper rash.

Equipment: Waterproof paper (*wax paper*) * _____

Soap for cleaning after bowel movement

Paper towel **for drying only**

Diaper

Tightly covered sanitary waste containers, lined with plastic (*one for soiled diapers and one for washcloths*).

Disposable gloves

Sanitizing solution (*1% bleach solution or its equivalent*).

Procedure:

1. Wash hands with soap and warm water and dry with disposable paper towel.
2. Gather equipment and put on diapering area.
3. Spread wax paper on changing table. **Cover entire length and width of pad.**
4. Pick up baby and place on diapering table.
5. Put on gloves (*if blood is present, medical disposable gloves must be worn.*)
6. Release diaper.
7. Using ankle hold to insure safety, remove soiled diaper.
8. Place soiled diaper on **wax paper** or into plastic bag.
9. Gently wash baby's bottom with * _____ downward cleansing, and dry with towel. Avoid hard rubbing. Baby's skin is very sensitive.
   - To cleanse girls, spread labia apart gently, wash and dry between skin folds (*cleaning **downward only** - cleaning cloth must not touch vaginal area if it has touched rectal area*).
   - To cleanse boys, merely wash and dry. In uncircumcised boy, **never** attempt to pull back the foreskin.
   - Use soap and rinse well if child had bowel movement.
10. Remove gloves.
11. Put diaper on child.
12. Wash child's hands.
13. Take child to safe area.
14. If blood is present on diaper table, put medical gloves on.
15. Discard soiled diaper, washcloth and towel, and wax paper into tightly covered sanitary waste container lined with plastic bag.
16. Sanitize diaper changing pad and table.
17. Remove gloves and discard in covered container.
18. **Wash hands with soap and warm water and dry with disposable paper towel.**
19. Record on child's record and note any unusual observations such as rash, loose bowel movement, bleeding, etc.

*** State what you will use for skin cleansing (*i.e., disposable wipe, terry washcloth, etc.*) and to cover changing table pad.**

Signature of health care consultant	Date signed (*month, day, year*)

HEALTH CARE PROGRAM FOR CHILD CARE
HEALTH RECORD - CHILD

State Form 49969 (R5 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date *(month, day, year)***		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* **Influenza (Flu)**					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			**or Chicken Pox Disease**	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner / physician assistant completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner / physician assistant	

ADDITIONAL NOTES AND INSTRUCTIONS

HEALTH CARE PROGRAM FOR CHILD CARE
RECORD OF ADULT PHYSICAL HEALTH EXAMINATION

State Form 49970 (R6 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name	Date of birth (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)	

MEDICAL HISTORY

I. List past hospitalizations / operations / accidents:

II. Vaccines / immunities:

☐ Measles	Month / year	☐ Mumps	Month / year	☐ Rubella (German Measles)	Month / year
☐ Chicken Pox	Month / year	☐ Scarlet Fever	Month / year	☐ Whooping Cough	Month / year
☐ Other:			Month / year	☐ Tdap Booster	Month / year

III. Conditions (*Please explain if present*):

Allergies:

Chronic health conditions:

Use of any drugs / medication:

Why?

PHYSICAL EXAMINATION

I. Mantoux TB skin test or ISDH approved screen *	Date (*month, day, year*)	Result (*in mm*)
Chest X-ray, if above screen is positive?	Date (*month, day, year*)	Result

Other laboratory test as ordered by physician:

II. Does this person have any health condition that would be hazardous to the person or to the children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No

If Yes, what modifications of normal activities are necessary?

III. Have you prescribed any medications and / or special routines (*such as diet*) which should be included in planning this person's activities?

☐ Yes ☐ No

Explain:

* Annual ISDH approved screening for tuberculosis is required.

Date of examination (*month, day, year*)	Signature of physician / nurse practitioner / physician assistant
Telephone number ( )	Printed name of physician / nurse practitioner / physician assistant

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
SUGGESTED FIRST AID DIRECTIVES

Part of State Form 45877 (R9 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
402 W. Washington St., Room W362
Indianapolis, IN 46204

CHOKING

(Conscious, ages one (1) and above) - Stand or kneel to the side of the child, have them bend over your arm and give five (5) forceful back-blows between the shoulder blades. Each back-blow should be a separate attempt to get the object out. If the five (5) back-blows do not get the object out, give five (5) abdominal thrusts. Stand or kneel behind the child, with your arms around their waist and make a fist, placing it just above the naval. With moderate pressure use your other hand to press the fist into the child's abdomen with five (5) quick, upward thrusts. Repeat five (5) back blows followed by five (5) abdominal thrusts until the obstruction is cleared, the child begins to cough, or becomes unconscious.

(Unconscious) - **Contact 911 and/or emergency services immediately and begin CPR.**

(Conscious Infants) - Have someone call 911 or, if you are alone, call 911 as soon as possible.
Support infant's head and neck. Turn infant face down on your forearm. Lower your forearm onto your thigh. Give five (5) back blows forcefully between infant's shoulder blades with heel of hand. Turn infant onto back. Place middle and index fingers on breastbone between nipple line and end of breastbone. Quickly give at least five (5) chest thrusts by compressing the breastbone one-half to one inch with each thrust. Repeat backblows and chest thrusts until object is coughed up, infant starts to cry, cough, and breathe, or medical personnel arrives and takes over.

(Unconscious Infants) - **Contact 911 and/or emergency services immediately and begin CPR.**

POISONING

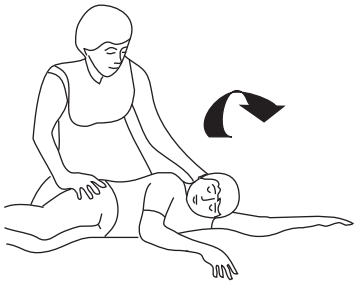
Call Poison Control Center (1-800-222-1222) immediately! Have the poison container handy for reference when talking to the center. Do not induce vomiting or give anything by mouth. Check the child's airway, breathing and circulation.

HEMORRHAGING

Use a protective barrier between you and the child (gloves). Then, with a clean pad, apply firm continuous pressure to the bleeding site. Do not move or change pads, but you may place additional pads on top of the original one. If bleeding persists, call a doctor or an ambulance. Open wounds may require a tetanus shot.

SEIZURE

Clear the area around the child of hard or sharp objects. Loosen tight clothing around the neck. Do not restrain the child. Do not force fingers or objects into the child's mouth. After the seizure is over and if the child is not experiencing breathing difficulties, lay him on his side until he regains consciousness or until he can be seen by emergency medical personnel. After the seizure, allow the child to rest. Notify parents immediately. If child is experiencing breathing difficulty, or if seizure is lasting longer than 5 minutes, call an ambulance at once.



ARTIFICIAL RESPIRATION (*Rescue Breathing*)

Position child on the back; if not breathing, open airway by gently tilting the head back and lifting chin. Look, listen, and feel for breathing. If still not breathing, keep head tilted back and pinch nose shut. Give two regular breaths, and then one regular breath every 4 seconds thereafter. Continue for one minute; then look, listen, and feel for the return of breathing. Continue rescue breathing until medical help arrives or breathing resumes.

* If using one-way pulmonary resuscitation device, be sure your mouth and child's mouth are sealed around the device.

(Modification for infants only) - Proceed as above, but place your mouth over nose and mouth of the infant. Give light puffs every 3 seconds.

SHOCK

If skin is cold and clammy, as well as face pale or child has nausea or vomiting, or shallow breathing, call for emergency help. Keep the child lying down. Elevate the feet if there are no leg injuries or pain.

Signature of healthcare consultant	Date signed (*month, day year*)

FIRST AID SUPPLY LIST

Part of State Form 45877 (R9 / 7-19)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W362
INDIANAPOLIS, IN 46204

INSTRUCTIONS: Post with stored medication and supplies.

Mild soap
Adhesive bandages
Gauze pads and tape
Medical gloves
1% bleach
One-way pulmonary resuscitation device (*artificial respiration mask*)

(*Keep in locked cabinet*)

Alcohol
Hydrogen Peroxide
Thermometer
Scissors
Flashlight
Medications, ointments only as follows: (*include name of medicine or skin product, dosage, frequency of use and reason to use for each item listed.*) *

* If no medication or ointments are included, form does not need to be signed by a physician or nurse practitioner.

Signature of healthcare consultant	Date (*month, day, year*)

RECORD OF MEDICATION ORDER

State Form 49968 (R4 / 7-19)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W362
INDIANAPOLIS, IN 46204

All medications, medicinal products, physician's sample medications, and medicinal skin care products given or used at a child care center must include the exact name of medication, dosage to be given, time to be given and reason for use. (*If used for fever, the degree of temperature must be stated.*) A prescriber order is valid for one (1) year.

1. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of child's healthcare provider	Date (*month, day, year*)

2. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of child's healthcare provider	Date (*month, day, year*)

3. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of child's healthcare provider	Date (*month, day, year*)

4. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of child's healthcare provider	Date (*month, day, year*)

5. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of child's healthcare provider	Date (*month, day, year*)