

IAT Parent information checklist

Philosophy

Inclusion is an attitude and a philosophy that welcomes and supports all children. Inclusion is a belief in every person's inherent right to participate fully in society. Inclusion conveys the idea that the community appreciates each child, sees each child's gifts and values children of all abilities being together.

Step by Step Checklist

If your child is participating in any Child and Youth Programs, please follow the following steps if you are given an Emergency Action plan from your provider/program: These documents are required before your child attends a CYP program.

Step 1:

Completely fill out page 1 of the Navy CYP emergency action. Please ensure a picture of the child is attached to the sheet. List all allergies and if your child has asthma. **(Note: You must obtain an Asthma Action plan from the physician if your child has Asthma).**

Step 2:

Completely fill out page 2 of the NAVY CYP emergency action plan if your child takes medication daily. Please list all environmental control measures, special precautions, dietary restriction and irritants. For each medication listed, please make sure the doctor documents if your child is to receive medication **"at home only," or "medication to be administered at CYP facility."** In the case that no medication is required, the doctor should document, **"no medication needed."** **(NOTE: If your child takes medication, please ensure the Medication Authorization form is filled out and signed by the Physician on Page 5).**

Step 3:

Completely fill out numbers 1 through 5 on page 3. Provide any additional instructions and/or guidance for CYP professionals. **(NOTE: Please ensure the Physician's name is SIGNED and STAMPED at the bottom of the sheet).**

Step 4:

Completely fill out NAVY CYP Permission for Release of information. This gives NAVY CYP to receive information from and to provide information to Naval Hospital Yokosuka. All information shared will stay and remain confidential.

Step 5:

Please submit all completed paperwork to your provider. (CDC, SAC, YS, TEEN, CDH)





NAVY CYP EMERGENCY ACTION PLAN

CHILD'S INFORMATION		
Child's Name	DOB	Place Child's Photo Here
Parent/Guardian Name	Home Phone	
Parent/Guardian Name	Cell Phone	
Emergency Phone Contact #1 Name	Contact #1 Phone	Contact #1 Additional Phone
Emergency Phone Contact #2 Name	Contact #2 Phone	Contact #2 Additional Phone

CHILD'S NEEDS (please describe)		
Allergies	Asthma	Other



NAVY CYP EMERGENCY ACTION PLAN

DAILY MEDICATION PLAN		
Name	Amount	When to Use
Name	Amount	When to Use
Name	Amount	When to Use
Name	Amount	When to Use

CHILD AND YOUTH PROGRAM ENVIRONMENT (Environmental control measures, special precautions and/or dietary restrictions)

IRRITANTS (Check all that apply)									
Animals	<input type="checkbox"/>	Bee/insect sting	<input type="checkbox"/>	Chalk	<input type="checkbox"/>	Molds	<input type="checkbox"/>	List Other:	
Dust mites	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Dust	<input type="checkbox"/>	Strong odors	<input type="checkbox"/>		
Food	<input type="checkbox"/>	Respiratory infection	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Other	<input type="checkbox"/>		
Pollens	<input type="checkbox"/>	Change in temperature	<input type="checkbox"/>	Smoke	<input type="checkbox"/>				



NAVY CYP EMERGENCY ACTION PLAN

EMERGENCY ACTION PLAN

1. Emergency action is necessary when the child has any one of the following symptoms:

2. Action:

3. Action:

4. Contact Parent/Guardian:

5. **Call 9-1-1** if the child has any one of the following symptoms:

SPECIAL INSTRUCTIONS

Please provide any additional instructions and/or guidance for CYP Professionals:

PHYSICIAN INFORMATION

Physician Name (Printed/Stamped)

Contact Information

Physician Signature

Date Completed

Navy Child and Youth Programs
MEDICATION AUTHORIZATION FORM

REQUIRING DIRECTIVE: OPNAVINST 1700.9

It is preferable that medication not be administered within the CYP. When possible, parents and physicians should adjust medication schedules so that the program staff are not responsible for administration. We recognize that this is not always possible and we will agree to administer any medication as follows:

- Written orders by a physician must be on file in order to administer any medication.
- Parent/legal guardian must sign the liability release.
- Child shall be monitored on the medication for 24 hours each time medication is prescribed before the program staff administers medication.
- Children who need medications administered for extended time periods, or that have special health concerns will be required to complete Identified Needs Intake Package and be reviewed by the Inclusion Action Team (IAT).

ALL INFORMATION IN THIS SECTION MUST BE COMPLETED LEGIBLY BY A PHYSICIAN

Name of child: _____

Name of medication to be administered by CYP staff: _____

Time of day and/or frequency medication is to be administered: _____

Duration of medication (dates): _____

Any known allergies: _____

Can this medication schedule be adjusted so the medication is administered outside the CYP hours only? Yes No

Physician Signature

Date of Order

PARENTAL CONSENT/WAIVER/RELEASE AND INDEMNIFICATION

I hereby give consent for the CYP staff to administer medication to my child as directed above by the physician. I agree to indemnify and hold harmless Navy Child and Youth Programs, MWR, a non-appropriated fund instrumentality of the United States Navy, and any other instrumentality of the United States, and their officers, agents, and employees from any losses, expense, damage, claim, suit, or judgment arising out of or resulting from administration of medication to my child. As the parent/legal guardian, I agree to assume all risk associated with administration of medication including inadequacy or failure of staff and I also assure the said medication is safe for my child.

Parent Name (PRINT)

Parent Signature

Date

AUTHORITY: P.L. 101-89, Sec. 1507, "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Department Regulations: E.O. 9397; and OPNAVINST 1700.9 "Child and Youth Programs."

PURPOSE: To provide Child and Youth Programs (CYP) authorization to administer medications to your child while receiving care at the program.

ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children.

VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to the CYP.



NAVY CYP PERMISSION FOR RELEASE OF INFORMATION

Navy Child and Youth Programs (CYP) are legally responsible for protecting personal and identifying information regarding enrolled children and families. As well as being legally bound to this code of confidentiality, we are also ethically committed to protecting the privacy of each of the children and families that we serve. CYP requires written permission to release information to other agencies or non-custodial individuals and to receive information from other agencies or non-custodial individuals.

EXCEPTION: The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g) mandates CYP professionals to report any suspected signs, symptoms, or disclosures of possible child abuse and neglect.

PLEASE PRINT:

I, _____, (parent's name) as legal guardian of _____ (Child's Name and Date of Birth) hereby give permission to Navy CYP to receive information from and to provide information to CYP Teen Center and IAT (Name of Agency).
Topic and purpose of information to be shared: _____ Health Information and Emergency Action Plan

This authorization is understood to expire one year from the date of signature, or when the child has been terminated from the program, whichever is earlier. The Parent/Guardian has the right to revoke permission at any time.

I understand that a photocopy or fax of this authorization shall have equal validity with the original.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date
CYP Director Signature/Title	Date