

DEPARTMENT OF THE ARMY
Walter Reed Army Medical Center
6900 Georgia Avenue N.W.
Washington, D.C. 20307-5001

MCHL-HN

MEMORANDUM FOR Evaluating Health Care Provider

SUBJECT: Medical Action Plan

1. The child you are evaluating today has been referred to Community Health Nursing for review of a special need prior to placement in a childcare setting in Child and Youth Services or an Family Child Care home (FCC). A special need is defined as any issue, challenge, diagnosis, and/or behavior that a child has which require medical or educational intervention, assistance or other accommodation.
2. Completion of the attached Medical Action Plan is intended to help provide the Special Needs Resource Team with a clear picture of the needs of this child and his/her plan of care. Please make recommendations based on the childcare setting and any necessary program adaptations to include staffing needs (adult/child ratio). To the maximum extent appropriate, Child and Youth Services seeks to include and enroll children with special needs in Child and Youth Services' programs.
3. Please support our parents by **providing the parent with two prescriptions for the same medication. This CYS requirement allows one medication to be kept at the CYS or FCC facility for the duration of the period prescribed. In accordance with AR 608-10 all medication labels must include: child's name, medication name, dosage strength, start date of therapy, end date of therapy, amount of medication, route of medication, indications for usage, and prescribing physician's name.**
4. After completing the Medical Action Plan, please return it to the parent. The parent will in turn provide it to Community Health Nursing.
5. If medication administration is to occur; medication and supplies will be provided by parent.
6. Contact Community Health nursing, at (202) 782-3964 for additional information and or concerns.

Community Health Nursing

Child's Name: _____
DOB: ____/____/____ (day/month/year)
Sponsor's last four: _____
This child has: _____

Medical Action Plan

Please attach a current plan of care, if available, related to the diagnosis to this packet.

1. List all diagnoses. _____

1. What physical/mental/behavioral limitations would interfere with the child attending childcare?

2. When was the child last evaluated for this condition? _____

3. When is the next scheduled appointment? _____

4. What services were provided at this appointment? _____

5. Is the child currently enrolled in the Exceptional Family Member Program? **Yes** **No**

6. Is the child currently enrolled in the Asthma Management Program? **Yes** **No**

7. Would you consider the child's medical condition to be stable? **Yes** **No**. If no, please explain.

8. Would environmental modifications need to be made by the daycare staff? (Examples: increase staff to child ratio, food/allergen restriction, behavioral intervention, limitations on being outside due to air quality) _____

9. Does the child have documented allergies? Seasonal? **Yes** **No** _____

10. List significant medical history (surgeries, hospitalizations, ER visits in the last calendar year, chronic conditions):

11. Current Scheduled Medications (please indicate if medication will need to be given in the center):

<u>Medication</u>	<u>Dose/Amount</u>	<u>Route</u>	<u>How Often Given?</u>	<u>Given in Center?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child's Name: _____
DOB: ____/____/____ (day/month/year)
Sponsor's last four: _____
This child has: _____

12. PRN Medications:

<u>Medication</u>	<u>Signs/Symptoms</u>	<u>Dosage/Route</u>
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____
D. _____	_____	_____

If symptoms are not relieved, immediately call:

- 1. Rescue Squad 911 _____
- 2. Parent _____ at _____
_____ at _____
- 4. Emergency Contact _____ at _____
_____ at _____

14. Describe, if any, the exact interventions the daycare providers would need to make on a daily/weekly basis to provide safe and appropriate care for this child.

Evaluating Provider's Printed Name: _____ Contact telephone number: _____

Evaluating Provider's Signature: _____ Date: _____

Parent/Guardian Authorization of Release of Medical Information:

I, _____, hereby authorize the release of medical information relevant to this referral to the Special Needs Resource Team (CDC), Child and Youth Services and the Community Health Nurse.

Signature

Date