



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.) <input type="checkbox"/> Institution <input type="checkbox"/> Private Secure Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Emergency Shelter Institution <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Within thirty (30) days of employment, and annually thereafter, each staff member will have a Mantoux tuberculin skin test.	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Volunteers having direct contact with children meet the same health examination requirements as paid staff.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4 – CONTROL OF PETS

A. Pets will be kept in the home. (If No, skip to the next section.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. If yes, what type of animals?	Number of animals
C. Pets kept in the home have been immunized against rabies, if indicated.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 ()
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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 <i>(month, day, year)</i>
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Printed name	Title <input type="checkbox"/> Owner <input type="checkbox"/> President <input type="checkbox"/> Board of Directors <input type="checkbox"/> Administrator
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