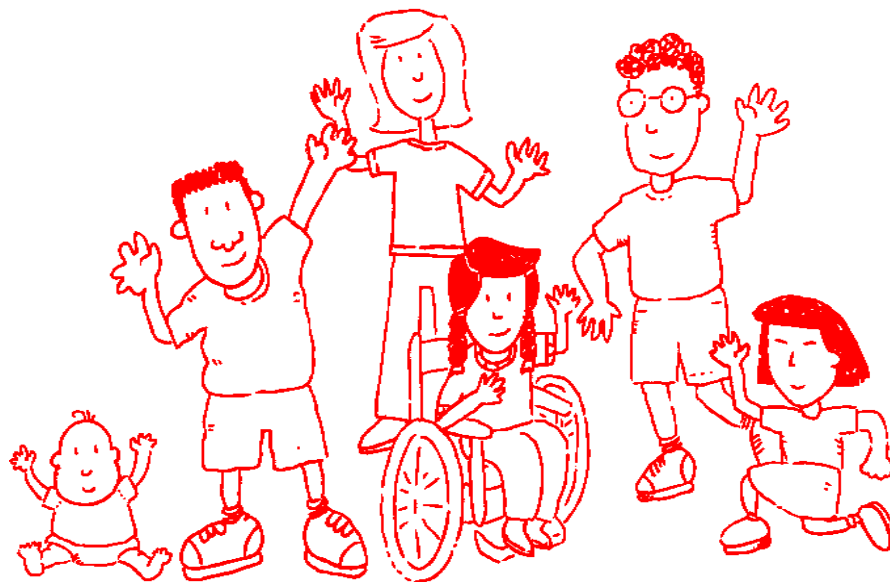


***Kentucky
Department for
Community Based Services***



Foster or Adopt a Child
Kentucky Cabinet for Families and Children

Medical Passport



Child's Name: _____

Medical Passport Introduction

Dear Care Provider *:

Assuring that the health needs of children in out-of-home care are met is a major responsibility for you and the child's Social Service Worker. This Medical Passport was developed to help with this important task. It has been designed to be used for all children in out-of-home care, including medically fragile children, who are placed in resource homes, emergency shelters, private child care facilities, psychiatric and medical settings. It is given to the Care Provider at the time the child is placed. The Medical Passport must be maintained continuously throughout placement and accompany the child as long as he remains in out-of-home care.

The **SOP** and forms referred to in this Passport can be found at:

<http://manuals.sp.chfs.ky.gov/Pages/index.aspx>

SOP states that “resource parents are to cooperate with the Cabinet in the medical and dental care planning for the child by: (a) scheduling appointments as needed; (b) keeping immunizations current; (c) reporting to the Cabinet all encounters with medical providers and any corrective or follow-up medical or dental care the child needs; (d) maintaining the medical passport with all medical information relating to the health history and on-going medical care of the child; (e) assisting DCBS in obtaining initial health screening within 48 hours of placement of the child; and (f) transporting children to necessary health-related (e.g. mental health, medical, dental, vision) appointment as needed.”

Why is the Medical Passport so important?

1. It ensures that all pertinent information pertaining to a child's health care is kept in one place. This benefits the child in providing timely service when basic medical records are needed at a moment's notice for medical care and emergencies or events such as case review, court, school enrollment, day care enrollment, and treatment planning conferences, etc.
2. Continuity of medical care is provided.
3. State Law requires that all children in out of home care receive regular medical care. State and Federal Law require the documentation of this care.
4. Care Provider Liability - Lack of documentation is equal to lack of services. In other words:
“If you don't write it down, it didn't happen!”
The medical passport documentation provides verification that this medical care is taking place.
5. A child's needs and history are more easily explained to birth parents and other Care Providers upon changes in placement or changes of Social Service Workers.

How do I use this Medical Passport?

SOP states that resource parents are to maintain “the medical passport with all medical information relating to the health history and ongoing medical care of the child”. If the child will be accompanied to the appointment or exam by a Social Service Worker or transportation aid in lieu of the Care Provider, then the Social Service Worker or Care Provider will assume responsibility for the passport, share it with the medical professional, and assure that all forms are completed. Care Providers should not assign these responsibilities to the child in the Care Provider's absence.

The medical passport includes tabs that are designed to be used with the three ring passport binder. Children who are medically fragile or who have special health care needs may require more space for documentation and record keeping. Therefore, the Care Provider may separate the tab sections into more than one volume as needed. Each child should have his/her own binder, even if siblings reside in the same foster home. Each tab section includes instructions on how to utilize the forms for that section. Other helpful hints are also included.

** In this Medical Passport, the term “Care Provider” is used to define the responsible person with whom the child lives in out-of-home care.*

What about all of the forms?

The forms specifically designed for use in the medical passport are the DPP-106 series. In March of 2007 the form sufexes were updated. The old and new designations in the forms top left corner are as follows:

FORM	OLD NUMBER	NEW NUMBER
“Authorization For Medical Treatment”	DPP-106A-1	DPP-106A
“Medical History” now called		
“Initial Health Interview with Family”	DPP-106A	DPP-106B
“Child Medical History and Annual Physical Exam”	DPP-106	DPP-106C
“Medical Appointment”	DPP-106A-2	DPP-106D
“Dental Care”	DPP-106A-3	DPP-106E
“Visual Screening”	DPP-106A-4	DPP-106F
“Mental Health Services”	DPP-106A-6	DPP-106G
“Medications History” now called		
“Prescription and OTC Medication Administration”	DPP-106A-5	DPP-106H
“Methamphetamine Exposure Medical Evaluation and Follow-up”	None	DPP-106I

Forms A through H will be used at some point during the child’s stay in out-of-home care. If you run out of forms or your Passport did not have a particular form to begin with, request them from the child’s Social Service Worker and be persistent. A blank copy of Prescription and OTC Medication Administration (DPP-106H) should be kept from which to make copies as needed. A blank Methamphetamine Exposure Medical Evaluation and Follow-up form (DPP-106I) is not included in this Passport. It is to be completed by a Social Services Worker at the time of a child’s medical evaluation. The Social Services Worker completes the form because the initial evaluation is to take place two to four hours after a child’s removal from the Methamphetamine environment.

It is very difficult to get forms filled out by medical professionals a few days or weeks after the appointment. Not having blank forms is no excuse for failing to include them in the passport. Photo copies of blank forms may be used. If photocopied forms are used, additional copies must be made for the case file once the forms are completed.

Other forms and documents used by medical professionals may be added to the passport in addition to the above forms. These may be filed under the appropriate related tab sections.

How are copies of the forms distributed?

Medical passport forms are either a single page or composed of carbonless paper forms with white and yellow copies. Once completed, the white copy or the original is to be kept in the passport binder. A photo copy or the yellow carbonless copy is to be given to the child’s Social Service Worker to notify him / her of the medical status of the child and is to be kept in the child’s case record. Photo copies or the yellow copies of medical, dental, and visual screening forms should be given to the child’s Social Service Worker within one week of the appointment. Photo copies or the yellow copies of medication forms should be given to the child’s Social Service Worker at the end of each month.

Passport forms in the child’s case file must be available for review by many service professionals. Medical professionals are encouraged to write legibly and press firmly. If you have a yellow copy and it cannot be read, please give the Social Service Worker a photo copy of the white original for the case file.

DO NOT allow the medical professional to keep the original completed forms. Encourage them to make photo copies and return the originals and carbons, if applicable, for passport use. You may also want to make copies of completed forms for activities such as day care, school, and camp registration/enrollment. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Important Information

Effective Date: _____

This page should be completed with current information once a child enters out-of-home care and should be updated using the “Important Information Updates” boxes on the next tab / page as needed. Past history information should be provided in the “Medical History” section.

Child’s name: _____ Date of Birth: _____

Race: American Indian or Alaskan Native Asian or Pacific Islander Biracial Black, Non-Hispanic
 Hispanic White, Non-Hispanic Other _____

Gender: Female Male Social Security Number: _____

In the following sections related to allergies and medical diagnosis, please write “unknown” in the space provided if the information is unclear from past or current history.

Medication Allergies: Medication: _____ Reaction: _____

Other Allergies (Please identify type and reactions.): _____

Medical Diagnosis or Special Medical Needs (in brief): _____

Date of Child’s Original Entry Into Out-of-Home Care: _____ Date of Child’s Most Recent Entry: _____

Parental rights terminated? Yes No

Name of Mother: _____

Custodial parent? Yes No

Address: _____

Telephone Numbers: _____

Name of Father: _____

Custodial parent? Yes No

Address: _____

Telephone Numbers: _____

Other Legal Guardian: _____

Address: _____

Telephone Numbers: _____

IMPORTANT INFORMATION

Important Information

IMPORTANT
INFORMATION

Child's Social Service Worker: _____ **Effective Date:** _____

Address: _____

County: _____ Region: _____

Telephone Number: _____ E-mail: _____ FAX Number: _____

Family Services Office Supervisor: _____ **Effective Date:** _____

Address: _____

Telephone Number: _____ E-mail: _____ FAX Number: _____

Pediatrician/Primary Care Physician: _____ **Effective Date:** _____

Address: _____

Telephone Number: _____ FAX Number: _____

Dentist: _____ **Effective Date:** _____

Address: _____

Telephone Number: _____ FAX Number: _____

Other Important Numbers (relatives, medical specialists, therapists, mental health, etc.):

Name:	Description:	Telephone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Notes:

Important Information Updates

Please photo copy this page as needed for additional updates.

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

IMPORTANT
INFORMATION UPDATES

Important Information Updates

Please photo copy this page as needed for additional updates.

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

Check one: Social Service Worker Supervisor Primary Care Physician Dentist
 Therapist/Counselor (Mental Health) Other _____

Name: _____

Address: _____

Telephone: _____ E-mail: _____ FAX: _____

Effective Date: _____

IMPORTANT
INFORMATION UPDATES

Medical Passport Tracking History

Date of Original Medical Passport Issue: _____

It is important that this medical passport accompany a child throughout his/her stay in out-of-home care for consistency and continuity of care. It is very difficult to recreate and/or relocate records when they are lost between placements. For this reason, Care Providers* are required to sign that the medical passport is received upon the child's entry into their home/facility. Please record the date, type of Care Provider, and signature in columns 1, 2, 3 and 4. For type of Care Provider, see key below.

When a child leaves a foster home/other facility (i.e. changes placement), the passport is to be returned to the child's Social Service Worker immediately. The Social Service Worker will then sign the date returned entry (columns 5 and 6), make a photo copy of this page for the child's case record and most recent Care Provider and forward the passport to the appropriate new Care Provider, or birth parent (columns 1, 2, 3, and 4). Additional space is provided on the back of this page for continuation.

When the child leaves for respite, Care Providers should make copies of the appropriate pages of the passport which may be needed the respite period. In some cases, extended respite may require that the entire passport be transferred to the respite provider. Care Providers may use their own judgment to determine if this is necessary. Use this page to transfer the passport in such cases.

1. Date given to Care Provider*	2. Care Provider* Signature	3.Type of Care Provider	4. Facility Name if applicable	5. Date Returned to Worker	6. Social Service Signature

MEDICAL PASSPORT TRACKING HISTORY

<u>Key for Type of Care Providers:</u>		
AH = adoptive home home	FH = foster home	PAH = pre-adopt
BH = birth home	H = hospital	PCC FH = private child care foster home
CP = care plus	J = juvenile justice facility	PRTF = psychiatric residential treatment facility
D = detention	MF = medically fragile foster home	R = relative/kinship care
E = emergency shelter	PCC GH = private child group home	

** In this Medical Passport, the term "Care Provider" is used to define the responsible person with whom the child lives in out-of-home care.*

Medical Passport Tracking History Continuation

Please make additional copies of this page as needed for continuation.

1. Date given to Care Provider*	2. Care Provider* Signature	3. Type of Care Provider	4. Facility Name if applicable	5. Date Returned to Worker	6. Social Service Worker Signature

MEDICAL PASSPORT TRACKING HISTORY

Key for Type of Care Providers:

- | | | |
|-------------------------|------------------------------------|---|
| AH = adoptive home home | FH = foster home | PAH = pre-adopt |
| BH = birth home | H = hospital | PCC FH = private child care foster home |
| CP = care plus | J = juvenile justice facility | PRTF = psychiatric residential treatment facility |
| D = detention | MF = medically fragile foster home | R = relative/kinship care |
| E = emergency shelter | PCC GH = private child group home | |

** In this Medical Passport, the term "Care Provider" is used to define the responsible person with whom the child lives in out-of-home care.*

Medical History

Introduction:

In order to provide for the immediate and ongoing medical needs of the child placed in out-of-home care, it is important to know as much as possible about the medical history. Prior to placement in out-of-home care, sources for this information are birth parents, relatives, prior out-of-home Care Providers, medical providers, medical records, school and day care records.



Most medical history information will be collected by the child's Social Service Worker prior to placement or at the initial out-of-home care conference, usually held within 5 days of placement. However, Social Service Workers and Care Providers may become aware of other medical history information during the course of the child's placement. All medical information received by the Worker or Care Provider must be shared between these two parties verbally as well as documented in the passport.

Any available medical records related to a child's history should be copied for the Medical Passport and shared with medical professionals. Care Providers may keep these documents in this section of the medical passport.

Using The Form ("Initial Health Interview with Family" DPP-106B) :

The child's Social Service Worker is to help the birth parent or primary care giver of the child fill out this form. It is important that the form be filled out completely and signed by the parent so that there is no question later as to the parent's or caregiver's understanding of the child's medical history, current state of health, and any medical needs and / or conditions requiring immediate response upon entry into out-of-home care.

Parents should be as specific as possible regarding types of allergies, special medical conditions, recent and past health problems and illnesses. Dates of illnesses or approximations should be recorded on this form. Surgeries should be listed specifically in the "other" section along with type and date of the procedure.

When changes or additions occur (such as allergies discovered, surgeries, and illnesses occurring in out-of-home placement like chicken pox, etc.), these are to be recorded on a new (additional) DPP-106A Medical History form and filed in this section with a photo copy or the yellow carbonless copy returned to the child's Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

The Medical History form should be discussed with the medical professional at the child's initial exam following entry into out-of-home care. Every effort should be made to complete this form prior to this initial exam.

Copies of Other Documents to be Included in this Section:

- Birth Certificate
- Immunization Record
- Most recent physical prior to child's entry into out-of-home care
- Significant medical records prior to placement

- Social Service Worker's assessment of the child upon entry into care
- Allergy information
- Care Provider assessment of the child upon entry to their home/facility
- Hospital discharge summaries prior to placement
- Mental health evaluations and testing prior to placement

Past Medical Professionals for this Child:

Please list medical providers prior to the child's placement in out-of-home care. Additional spaces are provided on the back of this page.

Name: _____
Address: _____
Type of Provider: _____
Telephone Number: _____
Dates: from: _____ to: _____
Name: _____
Address: _____
Type of Provider: _____
Telephone Number: _____
Dates: from: _____ to: _____

Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____	Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____
Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____	Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____
Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____	Name: _____ Address: _____ Type of Provider: _____ Telephone Number: _____ Dates: from: _____ to: _____

Notes:

Payment for Medical Services

Medical Insurance Cards

The majority of children in out-of-home care are eligible for medical insurance, and therefore will receive an insurance card to cover their general medical needs. Please be aware that not all medical facilities and providers accept the insurance card as a form of payment. Check with the child's Social Service Worker or your local Department for Community Based Services (DCBS) Family Support office for a listing of accepting providers in your area.

How do I know if my child is eligible for insurance coverage?

Following placement in out-of-home care, the child's Social Service Worker will apply for the medical insurance card within two weeks. It may then take up to a month for the card to be issued. Please understand that this process may be delayed if necessary documents such as birth certificates and / or social security cards are not accessible and need to be applied or reapplied for prior to application for the insurance card.

How do I get the insurance card if my child is eligible?

An insurance card is generally issued to the Social Service Worker in the child's name. It is mailed to the local DCBS office. There it will be copied for the file. The original card will be mailed to you.

What if I am waiting for an insurance card and my child in care needs medical care?

Often a child must first be removed from a birth parent's insurance before a card in the child's name can be issued. The child in your care will need appointments for medical care (i.e. at least a complete physical, dental, and vision exams) within the first two weeks of placement. You, the Care Provider need to make every effort to make and keep these appointments with the child's current medical provider. However, you do not need to wait on the insurance card before accepting an available appointment. If you go to an appointment before you have the child's insurance card **do not pay for medical services yourself or list your name or the Social Service Worker's name as the responsible party for payment. Contact the child's Social Service Worker just prior to the appointment for guidance concerning payment(s).**

How long do I keep my child's medical card?

Medical insurance cards should be maintained in the medical passport for the length of stay in out of home care. The insurance cards being issued are good from year to year so do not discard them.

Medical insurance cards are sent along with the child and this Medical Passport when he/she leaves your home/facility.

Private Insurance

Some children in out-of-home care remain eligible for private insurance under their birth parent's or guardian's health care plan. In this situation, the child's Social Service Worker will request a copy of the child's insurance card from the birth parent or guardian and provide a copy of it to you. You may contact the insurance company for a list of accepting medical providers in your area.

If the private insurance plan does not cover 100% of the medical, dental, or other related expenses, the child may be eligible for the Kentucky Medical Assistance Program as a secondary payment source. The child's Social Service Worker will apply for an insurance card for this purpose. Please refer to the information in the previous section entitled "Medical Insurance Cards."

Payments for Special Expenses

On occasion, you may encounter some medical procedure, medications, or related expenses for children in out-of-home care that are not covered by the child's available insurance.

Please talk with the child's Social Service Worker to arrange for a special needs payment before arranging services or paying expenses on your own.

Justification must accompany bills for medical expenses and state if the child was ineligible or if the service was not covered by Medicaid or private insurance.

Please remember that approval must be granted in advance of any treatment.

Unplanned Medical Expenses Occurring While Out-of-State

Prior to traveling out of state with a child in your care, contact the child's Social Service Worker to obtain approval. Obtaining prior approval for out of state travel assures that a child in your care will receive consistent and proper medical care. Ask specifically about the current procedure for payment of medical bills from out of state providers. **Do this well in advance of your travel date to avoid delays.**

Reimbursement for Planned Medical Care Both In and Out of State

Contact your Recruitment and Certification worker to obtain current information regarding approval for reimbursement of travel expenses in and out of state. You will need to be approved through the Department

of Medicaid to be reimbursed for medical transportation. Reimbursement for travel, expenses and medical treatments may require prior authorization by Medicaid. Your Recruitment and Certification worker will provide you with the Medicaid liaison's contact information. **Do this well in advance of your travel date to avoid delays.**

Copies of Other Documents to be Included in this Section, if applicable:

- Medical Insurance Cards
- Private Insurance Card
- Documentation to support special needs payments
- Out of State Travel Forms

Notes:

Authorization for Medical Treatment

Introduction:

Seeking medical care and treatment for the child in out-of-home care is not as simple as it may be for a biological child because you are not the child's biological or legal parent. **Care Providers are not authorized to sign for any medical services or treatment unless it is an emergency and the child requires immediate medical attention (see Procedures below).** Other parties such as the child's biological parent, in some cases, and the Cabinet, in all cases have legal rights, responsibilities, and liabilities in providing for this child. To properly involve the appropriate parties, protect yourself, and provide the best possible care for your child, make sure that proper authorization procedures are followed. Please copy this section for all respite providers so that proper procedures are followed in the absence of the primary Care Provider.

Authorization Procedures per SOP:

Type of Custody/Commitment	Situation	Approval by
Temporary Custody/Emergency Custody	Medical Services	Birth Parent or District/Family Court Judge by written approval
Temporary Custody/Emergency Custody	Emergency	Birth Parent, District/Family Court Judge, Social Service Worker (if parent and judge unavailable) Care Provider (if Worker unavailable)
Committed to Cabinet	Medical Services	Birth Parent or Social Service Worker
Committed to Cabinet	Emergency	Birth Parent or Social Service Worker or Care Provider (if Worker unavailable)
Parental Rights Terminated	Medical Services	Social Service Worker
Parental Rights Terminated	Emergency	Social Service Worker or Care Provider (if Worker unavailable)
Voluntary Commitment	Serious Illness/ Major Surgery	Birth Parent or Social Service Worker (if parents unavailable)
Voluntary Commitment	Emergency	Birth Parent, Social Service Worker, Care Provider (if Worker and birth parent unavailable)

Birth parents shall be notified as soon as practicable of any emergency medical treatment, serious illness, or major surgery. When a critical situation occurs, a caregiver initiates attempts to report the situation to the SRA, or designee, immediately. The SSW or other staff assigned by the SRA or designee notifies the child's family within one (1) working day. The Service Region Administrator and Commissioner are also notified by the worker in the case of serious injury to a child in out-of-home care.

Using The Form ("Authorization For Medical Treatment" DPP-106A)

The child's social worker is to complete this form upon the child's entry into out-of-home care. If the custody or commitment status changes, the worker is to fill out a new form with the appropriate date of the change and add it to this section. For your general information:

- ◆ Emergency Custody does not last longer than 72 hours.
- ◆ Temporary Custody lasts up to 45 days and in some cases may be extended by a judge's order.
- ◆ Commitment to the Cabinet has no time limit.
- ◆ Voluntary Commitment lasts for 6 months unless it has been extended upon formal review.

Please file the original or white copy and all subsequent DPP 106A-1 forms in this section of the Medical Passport. Give a copy or the yellow copy to the Child's Worker to be filed in the child's case record. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

AUTHORIZATION FOR MEDICAL TREATMENT

Medical Appointments

Introduction:

It is imperative that all children in out-of-home care be provided with proper medical care. It is **REQUIRED BY STATE LAW** that all children in out-of-home care receive a complete physical upon entry into out-of-home care and annual physical each year thereafter (**KRS 605.110**). Children under age two should have “well-baby” exams more often. Care Providers shall cooperate with the agency in the medical care planning for the child by scheduling appointments as needed per **SOP**.

What Does a Complete Annual Physical Include?

Your child’s annual physical is much more than a visit to the doctor’s office. It cannot be replaced or exchanged for a “sick visit” or follow up exam. Medically fragile children must also have an annual physical even though they may see a variety of medical professionals regularly.

There are a number of components that need to be completed annually to ensure that the child is continuing in good health and receiving proper care and to rule out and / or address special medical needs. An exam can be counted as an annual physical, provided that the following components are included:

- | | |
|---|---------------------------|
| √ height and weight | √ physical evaluation of: |
| √ vital signs | ☞ eyes, ears, nose |
| √ hearing and vision screening | ☞ throat, mouth, teeth |
| √ urinalysis | ☞ heart and lungs |
| √ blood screening for nutritional needs, lead poisoning and communicable diseases | ☞ abdomen |
| √ immunizations (see schedule on page 18) | ☞ extremities |
| | ☞ skin |
| | ☞ posture |
| | ☞ reflexes |
| | ☞ genitalia |

When Should I Take My Child to the Doctor?

Upon Entering Out-of-Home Care:

DCBS **SOP** states that “the Social Service Worker ensures that the child receives a physical health screening within forty-eight (48) hours of an order in which a child enters custody of the Cabinet, and treatment for any injury/illness that may be a result of maltreatment within twenty-four (24) hours.” And “ Within two (2) weeks of a child entering out of home care, either via a temporary order of custody or commitment, the SSW makes arrangements for a complete medical, dental and visual examinations.”

The purpose of the screening and examination is to document the medical condition of the child upon entry into care and is essential to identify any special medical needs or conditions. Please bring a completed Medical History form (DPP 106A) to this appointment.

It is often difficult to get a physical exam within the time stated in the SOP. Try to explain the special circumstances and see if an appointment can be scheduled as soon as possible. If not, document your efforts and notify the child’s Social Service Worker.

Should the child not come directly to you from his birth family (i.e. from a shelter, etc.), check with the Social Service Worker to see if a physical has taken place or is scheduled. If it has already taken place, a copy of the medical appointment form should be filed in this section when you receive the passport. This exam is required even if the child comes to you from a medical facility.

Examinations are not required for children who exit and reenter care within 30 days, unless the child’s circumstances indicate otherwise.

The American Academy of Pediatrics recommends that the initial health screening include the following, in addition to the components of an annual physical:

- ◆ Measurement of head circumference
- ◆ Notation of bruises, scars, deformities or limitations in function
- ◆ X-rays if history of physical abuse
- ◆ Sexually transmitted disease testing when indicated clinically or by history
- ◆ Pediculosis (lice) exam
- ◆ Developmental and mental health evaluation

Please let the physician know of any special needs or past circumstances which may affect the child’s comfortability with the exam such as history of sexual abuse, fears, etc

Annual Physical Exams:

Annual physical exams are **REQUIRED BY STATE LAW** for all children placed in out-of-home care (**KRS 605.110**). The appointment should be scheduled annually and within 12 months from the appointment of the previous year.

Prior to Age Two (“Well Baby”) Exams:

It is recommended by the American Academy of Pediatrics that the schedule below be followed for children under the age of two (this will assist in monitoring growth and development and assure that all required immunizations are received):

- 2 Weeks
- 2 Months*
- 4 Months*
- 6 Months*
- 11 Months
- 15 Months*
- 18 Months*



*Indicates when immunizations will coincide with these exams as required by the Center for Disease Control, 1996.

School Physical Exams are scheduled as follows:

- ◆ Before entering Kindergarten (or the Early Start/3-4 year-old programs)
- ◆ Before entering 6th grade (Middle School)
- ◆ Before participating in athletics

Immunizations will coincide with these exams as required by the Center for Disease Control, 1996.

These exams may take the place of the annual physical exam if they include the components listed on the previous page in the section entitled “What Does a Complete Annual Physical include?”

Female Children:

It is recommended by the American Council on Obstetrics and Gynecology that girls who are or have been sexually active have an annual pelvic exam and pap smear.

Older girls may prefer to see an OB/GYN instead of a pediatrician. The OB/GYN can conduct the annual physical required for all children in out-of-home care. Please explain to the doctor why the exam is needed and how to use the form.

Pregnant girls in out-of-home care are required to receive appropriate prenatal care. These appointments should be scheduled monthly as soon as the Care Provider becomes aware of her pregnancy. A prenatal exam may not take the place of the annual physical required for all children in out-of-home care. Though the two may occur together, the components of the complete physical should not be omitted (see *What Does a Complete*

Annual Physical Include? at the beginning of the **Medical Appointments** section).

Other:

Your child should be taken to the doctor when ill or in need of special evaluation. Please take special care to keep scheduled appointments and / or call to reschedule in advance. Many medical professionals will bill for missed appointments when not properly cancelled or rescheduled. Please remember to reschedule any cancelled or missed appointments to ensure that your child receives his or her proper medical care.

Using the Forms (“Child Medical History and Annual Physical Exam” DPP-106C and “Medical Appointment” DPP-106D)

The “Child Medical History and Annual Physical Exam” DPP-106C is used at a child’s very first medical check up upon entering care and each annual exam thereafter. The “Medical Appointment” DPP-106D form is to be filled out in its entirety at all other medical appointments: school physical exams, well baby exams, sick visits, specialist visits, prenatal exams, etc. Care Providers should fill in the date of the appointment, child’s name and date of birth, the reason for the appointment, and doctor’s name, address, and phone number to ensure that these are legible. Medical professionals are to fill in the results of the exam and sign the forms. Remember to press firmly if carbonless.

Please do not substitute school physical forms for this document. Explain to the medical professional that the Cabinet tracks medical care using this form.

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the medical professional in the child’s record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Copies of Other Documents to be Included in this Section:

- 📁 Doctor’s Clinic Notes about particular visits/ exams
- 📁 Emergency Department and Hospital Discharge Summaries
- 📁 School Physical Forms

Immunizations

Be on target with immunizations!

Immunization Schedule

Care Providers to children in out-of-home care are responsible for keeping immunizations current. A copy of the child's immunization record should be obtained and kept in the child's Medical Passport. The following is recommended by the Center for Disease Control, 2010. If your child in care is behind on, or has not had, their immunizations, there is an approved make-up schedule. For that schedule and more detailed information about immunizations please call toll free 1-800-CDC-INFO (1-800-232-4636) or visit:



<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

On the next page you will find a chart for children birth to 18 years of age and below is a list of descriptions for the vaccines listed on the chart.

This information is from the Immunization Action Coalition.

Exceptions to testing or immunization requirement. KRS 214.036

Nothing contained in Kentucky Revised Statutes (KRS 158.035, 214.010, 214.020, 214.032 to 214.036, and 214.990) shall be construed to require the testing for tuberculosis or the immunization of any child at a time when, in the written opinion of his attending physician, such testing or immunization would be injurious to the child's health.

Notes:

Vaccine Descriptions:

HepB: protects against hepatitis

DTaP: a combined vaccine that protects against diphtheria, tetanus, and pertussis (whooping cough)

Hib: protects against Haemophilus influenzae type b

PCV: protects against pneumococcal disease

Polio: protects against polio, the vaccine is also known as IPV

RV: protects against infections caused by rotavirus
Influenza: protects against influenza (flu)

MMR: protects against measles, mumps, and rubella (German measles)

Varicella: protects against varicella, also known as chickenpox

HepA: protects against hepatitis A

IMMUNIZATIONS

When Do Children and Teens Need Vaccinations?

Age	HepB Hepatitis B	DTaP/Tdap Diphtheria, tetanus, pertussis	Hib <i>Haemophilus influenzae</i> type b	Polio	PCV Pneumococcal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Varicella Chickenpox	HepA Hepatitis A	HPV Human papillo- mavirus	MCV4 Meningococcal conjugate	Influenza
Birth	✓											
2 months	✓ (1–2 mos)	✓	✓	✓	✓	✓						
4 months	✓ ¹	✓	✓	✓	✓	✓						
6 months		✓	✓ ⁵		✓	✓ ⁵						
12 months												
15 months	✓ (6–18 mos)	✓ ³ (15–18 mos)	✓ (12–15 mos)	✓ (6–18 mos)	✓ (12–15 mos)		✓ (12–15 mos)	✓ (12–15 mos)	✓✓ (2 doses given 6 mos apart at age 12–23 mos)			
18 months												
19–23 months		Catch-up ²	Catch-up ² (to 5 years)	Catch-up ²	Catch-up ² (to 5 years)		Catch-up ²	Catch-up ²				
4–6 years		✓		✓			✓	✓				
7–10 years	Catch-up ²	Catch-up ^{2,4}							Catch-up ²			
11–12 years		✓ Tdap								✓✓✓ ⁶	✓	
13–18 years		Catch-up ² (Tdap)		Catch-up ²			Catch-up ²	Catch-up ²		Catch-up ^{2,6}	Catch-up ^{2,7}	✓ ⁸ (given each fall or winter to all people ages 6 mos and older)

1. Your infant may not need a dose of HepB at age 4 months depending on the type of vaccine that your healthcare provider uses.

2. If your child's vaccinations are delayed or missed, they should be given as soon as possible.

3. This dose of DTaP may be given as early as age 12 months if it has been 6 months since the previous dose.

4. If your child is age 7–10 years and never completed the series of DTaP, they need to catch up now. For protection against pertussis, it's important that they and all teens get a dose of Tdap.

5. Your infant may not need a dose of Hib vaccine or RV vaccine at age 6 months depending on the type of vaccine that your healthcare provider uses.

Please note: Some children may need additional vaccines. Talk to your healthcare provider.

6. All girls and women ages 11 through 26 years should be vaccinated with 3 doses of HPV vaccine, given over a 6-month period. Boys and men ages 9 through 26 years may also be vaccinated with one of the HPV vaccines (Gardasil) to reduce their likelihood of getting genital warts. The vaccine may be given to children as young as age 9 years.

7. All adolescents and teens ages 11 through 18 years should be vaccinated with MCV4, as should unvaccinated young adults 19 through 21 years who are attending college. Booster doses will be necessary for those who got their first dose before age 16 years.

8. Only one dose of influenza vaccine is recommended for most children. However, those younger than age 9 years who are receiving influenza vaccine for the first time, or who received only 1 dose in the previous season (if it was their first time receiving influenza vaccine), should receive 2 doses spaced at least 4 weeks apart.

Disease	Caused by	Spread by	Signs & Symptoms	Complications
Chickenpox	Varicella Zoster virus	Air, direct contact	Rash, fever	Bacterial infections, meningitis, encephalitis, pneumonia, death.
Diphtheria	<i>Corynebacterium diphtheriae</i> bacteria	Air, direct contact	Sore throat, mild fever, membrane in throat, swollen neck	Heart failure, paralysis, pneumonia, death.
Hib Disease	<i>Haemophilus influenzae</i> type b bacteria	Air, direct contact	May be no symptoms unless bacteria enter blood.	Meningitis, epiglottitis, pneumonia, arthritis, death.
Hepatitis A	Hepatitis A virus	Personal contact. Contaminated food or water.	Fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice, dark urine.	Liver failure, death.
Hepatitis B	Hepatitis B virus	Contact with blood or body fluids	Fever, headache, malaise, vomiting, arthritis.	Chronic infection, cirrhosis, liver failure, liver cancer, death.
Influenza (Flu)	Influenza virus	Air, direct contact	Fever, muscle pain, sore throat, cough.	Pneumonia, Reye syndrome, myocarditis, death.
Measles	Measles virus	Air, direct contact	Rash, fever, cough, runny nose, pinkeye.	Pneumonia, ear infections, encephalitis, seizures, death.
Mumps	Mumps virus	Air, direct contact	Swollen salivary glands, fever, headache, malaise, muscle pain.	Meningitis, encephalitis, inflammation of testicles or ovaries, deafness.
Pertussis (whooping cough)	<i>Bordetella pertussis</i> bacteria	Air, direct contact	Severe cough, runny nose, fever.	Pneumonia, seizures, brain disorders, ear infection, death.
Polio	Poliomyelitis virus	Through the mouth	May be no symptoms, sore throat, fever, nausea.	Paralysis, death.
Pneumococcal Disease	<i>Streptococcus pneumoniae</i> bacteria	Air, direct contact	Pneumonia (fever, chills, cough, chest pain).	Bacteremia (blood infection), meningitis, death.
Rotavirus	Rotavirus virus	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration, electrolyte imbalance, kidney and liver disease, death
Rubella (German measles)	Rubella virus	Air, direct contact	Rash, fever, lymphadenopathy, malaise.	Encephalitis, arthritis/arthritis, hemorrhage, orchitis.
Tetanus (lockjaw)	<i>Clostridium tetani</i> bacteria	Exposure through cuts in skin	Stiffness in neck, difficulty swallowing, rigid abdominal muscles, muscle spasms, fever, sweating, elevated blood pressure.	Broken bones, breathing difficulty, death.

**IMMUNIZATIONS
CONTINUED**

Dental Appointments

Medical Alert! Medical Alert!

This child has a heart condition (describe) _____

Premedication prior to dental treatment is required.

Introduction:

Dental care for the child in out-of-home care is also very important. It is something that may have been overlooked by many birth families or previous placements, especially for children in constant transition. It is required by state law that all children in out-of-home care receive a complete dental exam upon entry into out-of-home care and annual exam each year thereafter (**KRS 605.110**). Care Providers shall cooperate with the agency in the dental care planning for the child by scheduling appointments as needed per **SOP**.

When Should I Take My Child to the Dentist?

Upon Entering Out-of-Home Care:

Arrangements are to be made for a complete dental exam for all children entering out-of-home care within the first two weeks of placement. This will document the child's dental condition upon entry into care and identify any special dental needs. As with medical appointments, it may be difficult to get the exam scheduled within a short period of time. Again, try to explain the situation and work with your dentist, document your efforts and notify the Social Service Worker.

Please let the dentist know of any special needs or past circumstances which may affect the child's comfortability with the exam such as history of sexual abuse, fears, etc.

Annual Exams and Cleaning:

These exams are **REQUIRED BY STATE LAW** for all children placed in out-of-home care (**KRS 605.110**). The appointment should be scheduled annually and within 12 months from the appointment of the previous year.

The annual exam usually consists of an x-ray, cleaning, and oral exam. The American Dental Association



recommends that young children wait until age three for this annual exam unless there is visible decay or other problems. The child's pediatrician or dentist can assist with other suggestions for young children.

Follow-up / Other:

Annual exams may often indicate the need for restorative work and require follow-up exams. Please take special care to keep these and all other dental appointments, cancelling and rescheduling as needed. Tooth decay does not improve with time!

The American Dental Association recommends routine exams and cleaning every six months, however the Kentucky Children's Health Insurance (medical card) will only pay for one annual exam. Should your child's special dental condition require more frequent exams, talk with the dentist about making a request for **pre-approval** to the Kentucky Medical Assistance Program. If this is denied, talk with the child's Social Service Worker about working out an alternative billing with the dentist and special needs payment (**KAR 1.350**).

Any time you can see decay, your child complains of tooth pain, or teeth are injured, the child should be taken to the dentist.

Referral:

Some children may require orthodontic or other special dental care (oral surgery, etc.) as recommended by the dentist. Children should have a complete dental evaluation before beginning specialty work. It is important to follow the course of treatment recommended by any specialist regarding frequency of exams, personal care, etc.



The Orthodontist and Other Oral Specialists

Orthodontic work must be pre-approved by medicaid if the child is medicaid eligible.

Usually the child is taken to an initial orthodontic evaluation appointment. The orthodontist then makes a report to the Kentucky Medical Assistance Program explaining the need and related costs. The approval process may take a number of weeks or months.

Once the report is submitted to the Kentucky Medical Assistance Program, do not switch orthodontists because the process must start all over. Do not switch orthodontists in the middle of a treatment course for the same reason. Services may not be reimbursed by medicaid in this situation.

If the child is not medicaid eligible, if private insurance does not exist or will not pay, or if medicaid denies approval for these services deemed necessary by the dentist / orthodontist, the child's Social Service Worker may arrange for a special needs payment through the Department.

Please remember that this approval must be granted in advance of any treatment.

Using the Form ("Dental Care" DPP-106E)

This form is to be filled out in its entirety at each dental/orthodontic appointment. Care Providers should fill in the date of the appointment, child's name and date of birth, and the dentist's or orthodontist's name, address, and phone number to ensure that these are legible. The dentist or orthodontist is asked to fill in all information related to the exam as indicated and sign the form. Remember to press firmly.

The "general appearance" section should state the reason for the particular appointment (i.e. annual cleaning, restoration needed, adjustment needed, appliance installed). It should also state the appearance / oral hygiene rating (i.e. good, fair, poor). The tooth status chart (middle section) should always be completed, even if there is no change from the last appointment. The follow-up appointment section should explain the need for the appointment (evaluation, restorative, annual, cleaning, etc.) and the date. If no follow-up is needed, enter the date of next annual exam on the line for the "next appointment."

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the dentist / orthodontist in the child's record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child's Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Notes:

Eye Appointments

Introduction:

Eye care for the child in out of home care is another important factor that may often be overlooked by many families. It is required by state law that all children in out-of-home care receive a complete visual exam upon entry into out-of-home care and annual exam each year thereafter (**KRS 605.110**). This may be done as part of the initial and annual physical exams. However, should the child in your care have vision needs, the annual exam should be completed by an optometrist or ophthalmologist. Some resource parents have learned from experience that children younger than school age should have exams by a pediatric ophthalmologists for the most accurate results. A vision examination by an optometrist or ophthalmologist is **required** by the Department of Education for all children entering school (**KRS 156.160**). Care Providers shall cooperate with the agency in the medical care planning for the child by scheduling appointments as needed as per **SOP**

When Should I Take My Child to the Eye Doctor?

Upon Entering Out-of-Home Care:

Arrangements are to be made for a complete vision exam for all children entering out-of-home care within the first two weeks of placement. If there is no known problem, the vision screening may be done at the initial physical. However, if the child has vision problems (i.e. is already wearing glasses), these arrangements should be made with an ophthalmologist to check prescription, etc.

Annual Exams:



These exams are **REQUIRED BY STATE LAW** for all children placed in out-of-home care (**KRS 605.110**). The appointment should be scheduled annually and within 12 months from the appointment of the previous year. If there is no known problem, the annual exam / screening may be done by the child's primary doctor as part of the annual physical. If a problem is discovered at the physical exam, the child should be taken to an ophthalmologist for further evaluation.

Follow-up / Other:

Please take special care to keep follow-up and all other appointments, cancelling and rescheduling as needed. Vision problems can lead to developmental delays, poor school performance, and behavior problems if left untreated.

Any time a teacher recommends an eye exam, the child complains of vision problems, or eyes are injured, the child should be seen by an ophthalmologist.

Using the Form ("Visual Screening" DPP-106F)

This form is to be filled out in its entirety at each eye exam. It may be filled out by the child's primary care doctor at the initial out-of-home care exam and subsequent annual exams if the child has no need to see an eye doctor for identified vision problems. Care Providers should fill in the date of the appointment, child's name and date of birth, and the medical professional's name, address, and phone number to ensure that these are legible. Medical professionals are asked to fill in all information pertaining to the exam and sign the form. Remember to press firmly.

The "observation and results" section should state the reason for the particular appointment (i.e. annual exam, prescription adjustment, etc.). It should also state the diagnosis and vision rating in each eye.

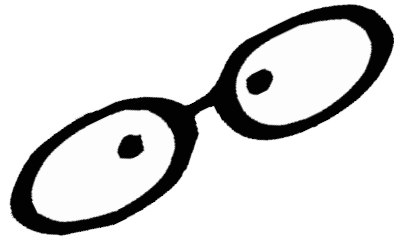
The follow-up appointment section should explain the need for the appointment and the date. If no follow-up is needed, the date of the next appointment should be the next annual exam.

If you forget forms, they may be filled out at a later date, mayhowever this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the doctor in the child's record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child's Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Glasses/Eye Wear

Lenses and some frames are Medicaid reimbursable. Your eye wear retailer will be able to assist you in selecting reimbursable frames. Should the child need frames that are not reimbursable or covered by private insurance, arrangements can be made with the child’s Social Service Worker for a special needs payment as per **SOP**.



Changes in prescription are covered by Medicaid as often as needed. Frame replacement is only covered once per year. Should your child need additional frames due to growth or frequent breakage, you will need to negotiate special needs payment through your community based services office for billing from the eye wear retailer or to be reimburs as per **SOP**.



Notes:

Medications

Medication Allergy Alert!

Medication:

Reaction:

Introduction:

Medications and their management are just as essential if not more essential than taking your child to the doctor, dentist, therapist, or specialist. Medication provides for continuation of the treatment phase beyond the medical professional's office.

Care Providers are required to administer medications as prescribed and document the use of these medications for a child in out-of-home care. Care Providers should take special care to follow the use and proper regimen for each medication in order to carry out the medical professional's intent and plan for treatment.

When Do I Give My Child Medication?

Prescription Medication:

Prescription medications are to be administered to a child according to the doctor's instructions on the medication bottle, box, etc. It is unlawful to change or skip dosage, change frequency, or medication without a doctor's order. Therefore, medication changes should be given to the Care Provider, by the doctor, in writing and changed on the prescription bottle. If a doctor does not provide the change in writing or if the change is made by telephone, request a written order immediately for your record and protection.

Care Providers can take a copy of a doctor's order on a prescription pad to the pharmacist and request that a new label be made. This will serve to protect the child and Care Provider. Many school and childcare centers will not administer medication other than the way it is indicated on the label.



It is also unlawful to give prescription medication to any other person than who is named on the prescription label.

SOP states that *“resource foster parents are to give a child's prescribed medications only with a physician's prescription or authorization, and are to dispense in the exact amount of any medication prescribed for a child by a physician or dentist and may not stop medication without a physician's orders.”*

It is expected that DCBS staff not routinely authorize certain psychotropic drugs without prior consent from birth parents. For this reason, the Care Provider should make every effort to inform the child's parent(s) and the child's Social Service

Worker of the plan to use this type medication even before it is prescribed. If this is not possible, SOP states resource parents are to inform the agency (child's Social service worker) within one (1) working day of any psychotropic medication prescribed for a child.

It is preferred that psychotropic drugs be prescribed by a psychiatrist, rather than a pediatrician, for management of mood, emotional or behavioral disorder.

Some prescription medications may not be covered by the child's Kentucky Children's Health Insurance Program (KCHIP) Card or other health insurance. Care Providers should ask the doctor for an alternative medication that is covered or seek approval from the child's Social Service Worker for payment of the medication as a special expense.

Over-The-Counter Medications:

Children in out-of-home care are at risk for the use of over-the-counter (OTC) medications because Care Providers and Social Service Workers often know little about the child's medical history. For this reason, Care Providers should check with the child's doctor **before** administering any OTC medications and administer them according to the package or doctors instructions.

If the doctor suggests that the medication should be given differently than instructed on the package, ask

that these instructions be written on a prescription pad or other written order. Also ask the child’s doctor for a standing order for any specific OTC medications the child may need. For the child’s protection and your own, keep a copy of these within the passport folder.

OTC medications are not harmless just because they are sold without prescription. They may cause side effects or interfere with prescription medications that the child is also taking.

Troubleshooting/Prevention of Medication Errors:

1. Before leaving the doctor’s office make sure:
 - a. you can read the prescription order form,
 - b. you understand the dosage and
 - c. you know how to administer the medication.
2. When picking up a new prescription from the pharmacy, make sure the label matches the prescription order given by the medical provider. If there is a discrepancy, contact the doctor before dispensing.
3. Keep each child’s medication separate and also separate from the medications of your own family members.
4. Observe the Six Rights of Medication Administration. To safely manage and administer a child’s medications one must fully understand the “six rights of medication administration”. These six rights are:
 1. Right Child
 2. Right Medication
 3. Right Dosage
 4. Right Route
 5. Right Time
 6. Right Documentation
5. Make sure you administer the medication at the right time of day. Check with the doctor to see for example if “4 times daily” means every six hours or 4 times during the time of day the child is awake. Ask the doctor if there can be any flexibility in the schedule and get this in writing if so. Know the following abbreviations:
 - q.i.d = four times daily
 - t.i.d. = three times daily
 - b.i.d. = twice daily
 - q.d. = once a day
 - p.r.n. = as needed
6. Do not measure liquid medication (prescription or OTC) using a standard kitchen utensil or measure. Use a medication spoon or oral syringe.

7. Request that your pharmacist cut tablets for you when the dosage required is only a partial tablet.
8. Crush tablets and mix them with food only when approved by the medical Care Provider. Sometimes this will cause medication to become ineffective.
9. Store medications as directed (i.e. away from light, refrigerate, etc.) and out of the reach / access of children.
10. After the individual has taken the medication it is very important that you make sure he/she has swallowed the medication. This practice will ensure they are not hoarding or ‘cheeking’ medications. This is especially important for someone who has a history of choking or aspiration. Offering a snack, something additional to drink, or spending extra time with this child will allow for increased monitoring to ensure that the medication has been safely swallowed.



Using the Form (“Prescription and OTC Medication Administration” DPP-106H)

SOP requires that all medication (prescription and over-the-counter) administered to a child in out-of-home care be documented. From a legal standpoint, if it isn’t written down, it didn’t happen. This is an area in which Care Providers are extremely liable. Document to protect your child and yourself.

This form is to be filled out by the Care Provider or whoever is giving the medication. Each time a child is administered a dose of medication it should be indicated with the appropriate date and time. Record each medication name, dosage, and if/when a refill is due. If doses are to be given at school, a separate form should be maintained there.

Information and observations such as side effects to watch for, reactions, or changes in medication should also be recorded on the form including the dates of each. Remember to get medication changes in writing from the doctor and ask that the medication label be changed as needed.

The following are also to be recorded on the form:

- a. Missed doses
- b. When a child refuses a dose
- c. When medication is transferred from your care
- d. When medication is destroyed

Notify the prescribing physician and the child’s Social Service Worker if a medication dose is missed or refused.

File the original in this section and provide a copy to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Mental Health

Introduction:

Providing for the mental health care of all children in out-of-home care is as essential as the provision of proper medical and dental care.

From infancy, a child's life becomes a complex and ever changing balance of systems interacting to form his or her environment. Child abuse and neglect place new forces on these systems, changing the balance and types of systems involved. Removal from the birth family home and placement into out-of-home care as a result of abuse, neglect, or dependency turns the child's systems and environment, as they are known, entirely upside down. Family, friends, surroundings, and schools all change in some form or fashion, and the child is often left with little ability to understand and possible feelings of loss, guilt, anger, and despair. It is therefore recommended that all children in out-of-home care be evaluated to assess the need for mental health services and that they receive those needed for support during placement in out-of-home care.

Mental health services can assist children and youth in communicating their feelings about separation and loss by providing a neutral party (therapist / counselor) for discussion. Mental health services benefit both the child and Care Provider by addressing additional areas such as anger and behavior management, socialization, abuse recovery, school performance, and parenting issues. The Care Provider should see themselves as potentially the strongest change agent who has contact with the child. They need to form a team with the therapist to understand, support, and respond strategically to the child's treatment issues.

When Should My Child Receive Mental Health Services?

Upon Entering Out-of-Home Care:

Arrangements should be made for an initial mental health screening to be performed by a qualified mental health professional for all children within 30 days of entering out-of-home care. It may be necessary for the child's Social Service Worker to make the referral for this service due to contract agreements between the Department and mental health agencies. Therefore, **Care Providers should discuss setting up the screening with the child's worker prior to scheduling an appointment.**

The mental health screening will serve to determine the child's mental health needs. When the screening indicates that further assessment or treatment is necessary, the Social Service Worker makes arrangements and documents service provision. Arrangements are made for initial service provision within two working days of the receipt of information

It will be helpful for the Care Provider and child's Social Service Worker to share as much of the child's history as possible with the mental health professional prior the assessment. This will help determine the method and techniques to be used and questions and topics to explore.

As Recommended By The Mental Health Professional:

Some mental health services may include brief or long term individual or group sessions, play therapy, art therapy, psychiatric services, testing, evaluation, medication, and

medication management. Following an initial assessment, the mental health professional will recommend what services should be provided and the frequency.

Most children participate in sessions weekly or twice monthly, while others may attend sessions daily, twice, weekly, or monthly. The frequency of services may often change during particular periods of stress or success. Periodic breaks in services may also be taken when a child has resolved his current issues or is not making progress.



Care Providers and Social Service Workers should work with the mental health professional to determine the best frequency for the child. Care Providers and workers may need to share transportation responsibility to enable the child to attend sessions as needed.

During Times of Crisis or Major Change:

Children and Care Providers need additional support during times of family crisis and change. At these times, Care Providers should schedule additional

sessions with the mental health professional if services are already in place or work with the child's Social Service Worker to make a referral for services.

Some times of crisis and change may include:

- ◆ A negative visit with birth parents
- ◆ Death (of a birth or foster family member or pet)
- ◆ Marriage or divorce of birth or foster parents
- ◆ Disruption or change in placement
- ◆ Addition of new child to placement or movement of another from placement
- ◆ Change of Social Service Worker
- ◆ Change of permanency goal (i.e. termination of parental rights and movement toward adoption)
- ◆ School-based behavioral/emotional problems suspension
- ◆ Legal issues (i.e. allegations against the child, criminal offenses, and preparation for court appearances)
- ◆ The onset of puberty

Medication Management

Children in out-of-home care who are on prescription medication for behavior management or for treatment of a psychiatric diagnosis will require periodic appointments with a psychiatrist for medication management and monitoring. These appointments will be in addition to sessions with therapists or counselors who are not physicians and cannot prescribe or medically monitor medication. Medication management appointments are often scheduled monthly or quarterly and usually coincide with the time that a prescription refill is due.

Care Providers should share information with the psychiatrist about the child such as any behavior changes, weight gain or loss, eating and sleep changes, and other medications the child is taking.

When psychotropic medications are being considered, the Care Provider should make every effort to inform the child's parent(s) and Social Service Worker of the plan to use this type medication even before it is prescribed. If this is not possible, SOP states resource parents are to inform the agency (child's Social service worker) within one (1) working day of any psychotropic medication prescribed for a child.

Psychiatric Hospitalization

Some children in out-of-home care may require temporary or longer term hospitalization in an acute psychiatric care facility or hospital.

The mental health professional and physician working with the child must make the recommendation and referral for hospitalization.

Once a child is admitted to a psychiatric hospital, it is essential that the Care Provider and child's Social Service Worker be involved as members of the treatment team. Care Providers who are planning to have the child return to their homes / facilities should take an active role in "parent" groups, visitation, and other support sessions provided. This will assist in planning for the child's discharge and success in treatment.

Using the Form ("Mental Health Services" DPP-106G)

This form is to be filled out in its entirety at **each** counseling / therapy session and medication management appointment. Care Providers should fill in the child's name, date of birth, therapist or counselor's name and telephone number, psychiatrist's name and telephone number, and the date of the session or appointment. Mental health professionals are to fill in the remaining information and sign the form. Remember to press firmly.

The form is separated into two sections: "Counseling / Therapy Session" and "Medication Management Appointment." The Counseling / Therapy Session section must be filled out by the child's counselor or therapist at each individual or group session even if the information remains the same as the previous session.

The Medication Management Appointment section must be filled out by the psychiatrist / physician at each medication management appointment.

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the mental health professional in the child's record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child's Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Copies of Other Documents to be Included in this Section:

- Mental Health Services Referrals
- Mental Health Evaluations/Psychological Testing
- DCBS Pediatric Symptom Checklists / Behavior Rating Scales
- School Psychoeducational Testing
- Behavior Management Plans
- Psychiatric Hospital Discharge Summaries
- Copy of psychotropic medications given by another physician



Medically Fragile and Children with Special Medical Needs

Introduction:

The term “medically fragile” is used to describe Kentucky’s children in out-of-home care who have a medical condition, documented by a physician, which can become unstable and change very quickly into a life-threatening situation. **SOP** lists some conditions that may require designation as medically fragile.

For a child to become designated as Medically Fragile the child’s Social Service Worker must seek approval. The Medical Support Section in DCBS’ Central office will review and advise the Regional Staff of eligibility. If a child is designated Medically Fragile there are additional Standards of Practice that become important. Each region has a designated Medically Fragile Liaison who will assist the Social Service Worker in ensuring that the child’s medical needs are addressed.



Preparation to Care for Medically Fragile Children

Initial and ongoing training for the medical fragile foster parent certification consists of the following:

- ◆ Join Hands Together training (14 hours) with two hour online pre-requisite and obtain Infant, Child and Adult CPR and First Aid is initially required
- ◆ Annual training offered twice a year in a conference style setting which provides the 16 hours required in:
 1. Growth and Development
 2. Nutrition
 3. Medical Disabilities
- ◆ DCBS medically fragile foster homes must complete annual training hours by the date they initially became a foster parent
- ◆ PCC/PCP medical fragile foster homes must be complete annual training hours by the date they became a medically fragile foster parent
- ◆ Infant, Child and Adult CPR and First Aid must be kept current according to certification date

Placement of Medically Fragile Children

A child who is designated as medically fragile should be placed in a resource home that is approved to care for medically fragile children. This involves additional training and/or a nursing degree.

Consultation regarding designation should occur before a child is placed to ensure the appropriate home is identified for the child’s specific medical needs.

Individual Health Plans

Each Medically Fragile child is to have an “Individual Health Plan (IHP)” to be completed with input from the birth parents, resource parents, medical/rehabilitative health Care Providers. A copy of this IHP is to be kept in the passport as well as sent to the Regional Medically Fragile Liaison. The IHP is to be reviewed quarterly and reevaluated every six months.

During the IHP a decision will be made whether the child continues to need the medical fragile designation. The DCBS Medical Support Section staff will assist and provide consultation.

The Monthly Report

Resource parents or other Care Providers of medically fragile children are to submit monthly reports (see sample form). These will be submitted to the child’s Social Service Worker and then forwarded to the Medically Fragile Liaison. Please include information such as diagnosis medications, therapies, appointments, specialists seen, procedures completed or planned, hospitalizations, height and weight, new developments, and any other pertinent information or changes occurring during the month. If you do not already have a preferred format, a reproducible sample report form is printed on the back of this page. The child’s monthly report information may in fact need more space than that which is provided in the sample. Please use additional sheets or redesign your own form including the same information as needed. File copies of your reports in this section.

Copies of Other Documents to be Included in this Section:

- Therapy Notes
- Tube Feeding Flow Sheets for Intake Monitoring
- Infant Stimulation Notes
- Articles and Pamphlets Specific to Child’s Condition
- Apnea Alarm / Event Records
- Education / IEP Plans Outlining Medical Adaptations for the Child During School

MEDICALLY FRAGILE AND
CHILDREN WITH
SPECIAL NEEDS

MEDICALLY FRAGILE MONTHLY REPORT

DATE: _____

Child's Name: _____ Child's Birthdate: _____

Foster Home: _____ Date of Placement: _____

Child's Weight: _____ Height/Length: _____

I. Overall Diagnosis and Care Needs: _____

II. Medications: _____

III. Physician(s) Name(s): _____ Area of Specialty: _____

IV. Medical Appointments: Most Recent and Future: _____

V. Change to Medications: _____

VI. Daily Medical Procedures/Treatment: _____

VII. Nutrition/Feeding Procedure: _____

VIII. Medical Emergencies since Last Monthly Report: _____

IX. Services: Therapies (O.T., P.T., Speech, Infant Stimulation): _____

Medical Equipment Company: _____

School: _____

Commission Nurse Visit: _____ Home Health Visit: _____

Counseling: _____

X. Family Visits: _____

XI. Comments or Concerns: _____

Foster Parent Signature, Date

Phone Number/Email Address

Provide Original to child's Social Service Worker.

Child's Social Service Worker sends a copy to: Medically Fragile Liaison, R&C Worker and Designated CCSCHN nurse.

**MEDICALLY FRAGILE AND
CHILDREN WITH
SPECIAL NEEDS**

Drug Endangered Children

Introduction:

There is a strong likelihood that children in out of home care have been endangered due to exposure to drugs or drug environments. Such exposure may make the child more vulnerable to certain medical, mental/emotional and developmental problems. It is therefore important that screenings, assessments, exams and interventions are administered at particular intervals following the drug exposure.



Responses:

Children may respond differently to environmental drug exposure based on:

- ◆ The age of the child,
- ◆ The length of exposure,
- ◆ Chemicals to which they are exposed,
- ◆ The individual child's physical functioning,
- ◆ The type of exposure (airborne toxins, direct skin contact, ingestions, injections), and/or
- ◆ Familial life style issues

Caution!

You should avoid quick conclusions concerning the origin of many physical, developmental, and behavioral symptoms exhibited by these children. Many of the damaging effects of abuse and neglect will contribute to some of the same symptoms. A medical assessment is needed to make the determination if intervention is appropriate.

Methamphetamine:

If the child was removed from a methamphetamine production site (lab), they should have been examined and screened at a hospital emergency room prior to coming to your home. The child should also have been showered or bathed and put in clean clothing, including shoes, at the hospital or at the removal site. If this procedure has been followed, the child should present no contamination risk to you or your family. [\(CHILD\(REN\) EXPOSED TO METHAMPHETAMINE PRODUCTION \(METHLAB\) INVESTIGATIONS\)](#) contains the procedures a worker is to follow when removing a child from a meth contaminated environment.

During the visit to the hospital emergency room, a health provider should:

1. obtain a urine sample, preferably within 2 hours (possibly up to 12 hours),
2. perform a medical assessment prior to placement and
3. assure a complete change of clean clothing for the child.

If a child is placed without this occurring, don't panic. The resource home can simply wash the child with soap and water, discard the old clothing, including shoes, and provide new clothing.

The resource parent needs to know the plan for a continued medical and developmental assessment. This plan also needs to be shared with the health care providers for their education. The medical and developmental assessment is contained on the Drug Endangered Child form.

Although exposure to any drug environment creates risks for children, methamphetamine exposure (presence in a meth lab or presence when meth is being smoked) poses, perhaps, the most immediate physical risk. Some meth exposed children may experience:

- ◆ respiratory problems (some will exhibit asthma-like symptoms),
- ◆ irritation of the eyes, nose, and bronchial system,
- ◆ decreased appetite,
- ◆ increased heart rate,
- ◆ abnormally high body temperature,
- ◆ rashes or rash like lesions,
- ◆ abdominal pain, vomiting, and/or diarrhea,
- ◆ vacillations between sleepiness or exaggerated activity,
- ◆ language delay (for very young children) and other learning problems,
- ◆ some potential memory problems,
- ◆ depression and withdrawal,
- ◆ decreased attention span and concentration problems,
- ◆ mood swings,
- ◆ guilt or
- ◆ shame

Many of these symptoms may be short term and the child may normalize quickly after removal from the toxic environment. It is unknown at this time if exposure to drugs or dangerous chemicals used to produce methamphetamine will have long term implications. This is part of the reason it is important to carefully follow the accompanying medical and developmental routine.

Using the Form (Methamphetamine Exposure Medical Evaluation and Follow-Up - DPP106I)

All children that have been exposed to methamphetamine, or the chemicals used to produce methamphetamine, shall be taken to an emergency room or appropriate medical facility for a complete medical assessment. At the time of the initial evaluation, the State Social Services Worker completes the DPP106I Methamphetamine Exposure Medical Evaluation and Follow-Up Form.

Note for State Social Services workers:

The Methamphetamine Exposure Forms may be accessed from the on line policy manual. The link to the on-line policy manual is:

<http://manuals.sp.chfs.ky.gov/Pages/index.aspx>

Click the “Forms Browser” link on the bottom of the main page under “Content”. On the forms page you may find the form by its number - DPP-106I or by its name “Methamphetamine Exposure Form.” Please check SOP often for changes in the protocol for dealing with methamphetamine exposed children.

Notes:

Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs With Addendum for Vulnerable Adults

November 1, 2005

For the Social Services Worker

Immediate Response:

Assessment

Assess the child or vulnerable adult for obvious injury of distress; if any of the below examples are noted, **ACTIVATE EMS IMMEDIATELY.**

Examples include but are not limited to:

- ◆ Rapid Breathing
- ◆ Difficulty Breathing
- ◆ Appears ill
- ◆ Injuries that are worrisome such as burns
- ◆ Lethargy (sluggishness, apathy)
- ◆ Somnolence (Sleepy or Drowsy)
- ◆ If there is an explosion
- ◆ If there are active chemicals at the scene
- ◆ EMS, if contacted, will make decisions regarding need for emergency intervention including full documentation

Cleansing or Containment

- ◆ Should occur prior to transport
- ◆ Gloves should be worn so as not to expose worker
- ◆ Clothing should be removed
- ◆ Cleanse the hair and skin to child or vulnerable adult. a warm shower is adequate and preferable to a bath
- ◆ New clothing should be given to child or vulnerable adult as all the clothing inside the area where the methamphetamine lab is located is considered contaminated.
- ◆ If unable to cleanse, place a sheet on car seat for transport to an acceptable facility

Collect

- ◆ Collect urine from potentially exposed children and vulnerable adults as soon as possible, preferably within 2 hours of removal
- ◆ Urine should be screened quantitatively for drugs of abuse (this should indicate the number of particles found not just positive or negative results)
- There are **NO ACCEPTABLE** levels of methamphetamine in children.

Within 2-4 hours:

Medical Examination

- ◆ The child or vulnerable adult should be evaluated in Emergency Room, Physician's Office, etc. by a qualified medical Professional.
- ◆ Includes vital signs, a thorough lung examination, respiratory rate and oxygen saturation on room air.
- ◆ Blood tests: CBC with Differential, Chemistry Panel to include BUN and Creatinine and Liver Panel
- ◆ In children and vulnerable adults a chest x-ray, 12 led EKG and pulmonary function tests if clinically indicated

Within 72 hours:

- ◆ If Liver Panel is elevated, Hepatitis B and C panels should be evaluated.
- ◆ Mental Health Evaluation
- ◆ Dental evaluation
- ◆ For children, a developmental evaluation with special attention to speech, language and motor skills

Follow up:

- ◆ For children, repeat the medical examination in 30 days, 6 months and 1 year.
- ◆ A medical examination follow-up for vulnerable adults is at the discretion of their medical practitioner as some vulnerable and elderly adults may be more sensitive to cardiac and respiratory effects of methamphetamine chemicals.
- ◆ For children, follow-up developmental recommendations as needed
- ◆ In both children and vulnerable adults follow-up mental health recommendations as needed.

**Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs
With Addendum for Vulnerable Adults
November 1, 2005**

For the Emergency Department of Physician's Office

Immediate Response:

Children should have at least a preliminary decontamination at the scene to include removal of clothing and cleansing of hair and skin before transport.

Medical Examination:

- ◆ Complete Medical Examination to assess Acute Medical Needs
- ◆ Urine for Toxicology (quantitative) COLLECTED AS SOON AS POSSIBLE, PREFERABLY WITHIN 2 HOURS, should be submitted to a lab that screens and reports for the level of detection and not just NIDA standards. Chain of evidence forms may be utilized of usual medical protocols for toxicology screens should be followed.
- ◆ Thorough Pulmonary Examination (minimum standard for the symptomatic child):
 - Vital signs
 - Respiratory Rate
 - O2 Saturation
 - CXR
- ◆ Labs (can be done acutely or within 72 hours):
 - CBC with Differential
 - Chemistry Panel to include BUN and Creatinine
 - Liver Function Test

Vulnerable adults, including the elderly, may be more sensitive than children to the cardiac and respiratory effects of toxins found in a methamphetamine lab. O2 sats, ECG and CXR are recommended.

Forms



FORM

NUMBER

“Authorization For Medical Treatment”	DPP-106A
“Initial Health Interview with Family”	DPP-106B
“Child Medical History and Annual Physical Exam”	DPP-106C
“Medical Appointment”	DPP-106D
“Dental Care”	DPP-106E
“Visual Screening”	DPP-106F
“Mental Health Services”	DPP-106G
“Prescription and OTC Medication Administration”	DPP-106H
“Methamphetamine Exposure Medical Evaluation and Follow-up” (if applicable)	DPP-106I



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