Court Appointed Special Advocates

Medical Advocacy Training

CASA
Court Appointed Special Advocates
FOR CHILDREN

NEW JERSEY

VOLUNTEER MANUAL

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Chapter 1 Training Goals and the Role of the CASA Volunteer in Medical Advocacy

Introduction

The primary goal of CASA Medical Advocacy is to assist with ensuring that children are receiving any and all healthcare needed to keep them in optimal health while they are in out-of-home placement. This includes regular well-care, dental care, and immunizations, as well as any other necessary healthcare services based on their unique, individual needs. From the time of CASA appointment until permanency is achieved and CASA involvement is terminated, the role of the CASA volunteer is to collaborate with the child's caseworker, nurse, doctors, caregiver(s) and child so that appropriate medical care (routine or otherwise) is provided in a timely, effective, and culturally sensitive manner. In doing so, the CASA volunteer should be sure to view the child as a whole, taking into consideration their needs for permanency, as well as their physical, emotional, educational, and healthcare needs.

In seeking to ensure that their assigned child's healthcare needs are met, the CASA volunteer, with the support of CASA staff, will use their investigative and advocacy skills to:

- Gather information regarding the child's health status, immunizations, assessments, and care provided to the child; this may include not only gathering information, but also filling in information gaps where appropriate.
- Help to ensure that any/all specific healthcare needs of the child are being met (including regular well-care, dental care, and immunizations, as well as specialized care if needed).
- Provide the Court with timely, objective, and unbiased information based upon the information gathered; this will allow the Court to make well-informed decisions on the child's behalf.

Medical Advocacy Initiative Goals

It is NOT the goal of this training to turn CASA volunteers into experts regarding the medical and healthcare needs of children. CASA volunteers serve as advocates, not medical professionals, and, as such, should not be diagnosing children.

Accordingly, the goals of this Medical Advocacy Initiative are to:

- Provide CASA volunteers with the tools, knowledge, and ability to take a proactive role in collaborating to ensure that the healthcare needs of children in placement are met.
- Enable CASA volunteers to identify informational gaps, areas of concern, and potential areas of risk for child health, and to know where to find appropriate professional support when needed.
- Ensure that CASA volunteers understand the importance of well-child care, immunizations, and the overall system of health care for children in placement.

Each chapter of this manual is designed to provide the CASA volunteer with information, highlight important points of advocacy in each subject area, and acquaint the volunteer with specific forms that they may see or potential tools that they can use in the process of advocating for the healthcare needs of their assigned child.[1]

In order to fully understand the manual and its contents, the volunteer can reference the list of commonly used acronyms and abbreviations at *Appendix A – Acronyms and Abbreviations*.

Why Medical Advocacy is Important

There are several reasons why it is important for a CASA volunteer to provide Medical Advocacy for children in placement to whom they are assigned. Many of these children enter placement without having had consistent attention paid to their medical and healthcare needs. Then, once they are in care, changes in placement may result in lost records, instability in the Medical Home, or inconsistencies in both well-care and care for special medical needs.[2]

As a result, opportunities may have been missed to identify and/or address specific medical conditions, abnormal lab values, and proper immunizations and well-child care, as well as other important issues such as developmental delays, behavioral issues, and the effects of trauma.

Research contained in an October 2015 technical report from the American Academy of Pediatrics found that children and youth in out-of-home placement "present with complex and serious physical, mental health, developmental, and

[1] The CASA volunteer should understand, however, that forms may change over time, and additional forms may be added. As such, no manual can truly be all-inclusive.

[2] While there are numerous technical definitions of "Medical Home," the term is used here to refer to a consistent primary care physician/pediatrician who provides for the child's basic health care needs while helping the child's family access, coordinate, and understand specialty care and arrange for such specialty care if necessary, usually via referral. Ideally, the Medical Home provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

psychosocial problems rooted in childhood adversity and trauma. As such, they are designated as children with special health care needs."[3] While noting that it is common for children's health problems to have gone undiagnosed and untreated before placement, startling statistical information from that report includes the fact that:

- 30%-80% of children come into foster care with at least 1 physical health problem, with fully one-third having a chronic health condition
- 46% to 60% of children younger than 6 years have a developmental disability that qualifies them for services.
- Up to 80% of children in foster care enter with a significant mental health need.
- Up to 20% of children in foster care enter with significant dental issues.
- Approximately half of youth in foster care have chronic medical problems related to behavioral concerns.[4]

Thus, it is very important for the CASA volunteer to work with DCP&P, the Court, and medical and behavioral health professionals to ensure that health issues are addressed early on and consistently during the child's time in placement.

Volunteer Goals Regarding Medical Advocacy

The role of the CASA volunteer is to be aware of the child's medical and healthcare needs, spot potential issues, know where to go to alert the correct individuals or professionals as to the potential issues, and help to ensure that the child receives timely and appropriate healthcare services. An individual CASA volunteer's role can be compared to that of a conscientious care-taker – someone who could not necessarily diagnose the child but who is diligent in ensuring that medical/health issues are addressed in a timely and appropriate manner, and in the best interest of the child.

In order to ensure that the child is receiving timely and appropriate healthcare services, CASA volunteers should:

- Communicate and collaborate with caregivers, family members, child welfare system stakeholders and healthcare professionals involved with the child
- Gather baseline medical information
- Confirm the provision of routine well-child care and immunizations for the child

[3] Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, Moira A. Szilagyi, David S. Rosen, David Rubin, Sarah Zlotnik, the COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, the COMMITTEE ON ADOLESCENCE and the COUNCIL ON EARLY CHILDHOOD, Pediatrics Oct 2015, 136 (4) e1142-e1166; DOI: 10.1542/peds.2015-2656

[4] Id.

- Be aware of the status of the child's health condition
- Be mindful and vigilant regarding potential areas of unmet health needs
- Follow up on or confirm provision of recommended services
- Ensure that a Health Plan is in place for the child
    - For children with special medical needs, the Health Plan should outline those special needs and address how they will be met, as well as outline the routine healthcare services that should continue to be provided.
    - For children without special medical needs, the Health Plan outlines routine healthcare services that are to be provided (such as regular well-care, dental, and vision care).

Chapter 2 Department of Children and Families Coordinated Heath Care System for Children in Placement

Introduction

In May of 2007, the Department of Children and Families (DCF) adopted a model of coordinated healthcare for children in placement that emphasizes continuity of care, provided in a manner that is sensitive to the child. A key component of this is the idea that a child should have an identified Medical Home – a consistent primary healthcare provider.

At the heart of this model is the implementation of Child Health Units (CHUs) which are co-located in each of the 46 local DCP&P offices. CHUs provide a proactive approach to meeting a child's healthcare needs and are a positive result of child welfare reform in New Jersey. Further, they coordinate the delivery of healthcare for the child from the moment of placement until the child achieves permanency.

In this chapter, we will explore the role of the CHU and the Health Care Case Management provided by DCF.

Child Health Units (CHUs)

CHUs have been developed in each DCP&P local office to ensure the delivery of coordinated health care for children in out-of-home placement and to support the care provided by the child's Medical Home. CHUs are staffed by Child Health Nurses and administrative support staff whose collective responsibilities include:

- Establishing a health baseline when a child enters placement (through collection of information from family, previous health providers, and the child, as appropriate).
- Performing Pre-Placement Assessments within 24 hours of the child's removal or gathering documentation of the Pre-Placement Assessment when the child receives one within the community.
- Obtaining and reviewing medical records.
- Ongoing retrieval and review of children's medical/health reports while the child is in out-of-home placement.
- Scheduling Comprehensive Health or initial physical health examinations.
- Ensuring the appropriate flow of health information to/from providers.
- Monitoring follow-up and response to the child's health plan.
- Providing follow-up care and/or support to the Medical Home (and assisting the resource home in identifying a Medical Home for the child if needed).

- Documenting health information.
- Coordinating and collaborating with DCP&P staff, caregivers, community providers, youth and families (both resource and birth).

The role of the Child Health Nurse is to be the health care case manager for each child in out-of-home placement, from the time the child is removed by DCP&P until the child achieves permanency. The Child Health Nurse focuses on:

- Physical Health
- Mental / Behavioral Health
- Family Engagement

CHU nurses are currently employed by the Rutgers University FXBC School of Nursing under a contract for services with the DCF.

Health Care Case Management for Children Entering Out-of-Home Placement

As soon as a child is removed from his/her home, an assessment is made as to the level of medical care the child requires. If emergency treatment is needed, the child is taken to a hospital emergency room. If there is no indication of need for emergency care, the child is taken for a Pre-Placement Assessment (PPA) as described below.

The *Health Care Case Management* flowcharts in your manual will be helpful insofar as they provide an overview of the interventions and healthcare management activities undertaken in the Child Health Units, both initially and ongoing for children in placement as well as youth aging out. The flowcharts do not represent policy or prescriptive requirements, but rather an overview of services, especially since interventions will vary based on the child's individual needs and circumstances. You will find an initial flowchart for all children entering care, and covering both the initial care for children entering out-of-home placement, as well as ongoing health care, and behavioral health care and case management. Two additional flowcharts cover health care case management for youth transitioning into adulthood, and youth aging out of foster care.

The following examinations and screenings are unique to children in out-of-home placement.

Pre-Placement Assessment (PPA) within 24 hours

The first step in ensuring a child's well being upon entering out-of-home placement is the PPA. When a child enters placement, DCF/DCP&P requires that a child receive an assessment for the purposes of determining any immediate health needs. DCP&P guidelines require that children receive a PPA within 24 hours of placement. The purpose of the PPA is to evaluate whether children entering care:

- Appear free of contagion;
- Appear free of injuries and/or bruising requiring immediate medical attention and/or documentation and referral to a Regional Diagnostic Treatment Center;
- Appear free of acute health issues requiring immediate medical attention; and
- Have health issues of which the caregiver needs to be aware at the time of placement.

Ideally, the PPA will be conducted by the child's own physician. If the child's physician is unknown or unavailable, or if the child does not have a physician, then the PPA may be performed by a nurse at the CHU or by a partnering community provider or community PPA site.

In your manual, you will find a DCP&P *PPA Form* – this is the form typically used to document the occurrence of a PPA in the child's DCP&P/CHU Medical Records as well as any needs the child may have as outlined above. Copies of this form should also have been provided to the child's caregiver and caseworker once complete.

Comprehensive Medical Exam (CME) within 30 days

The next step in terms of a child's medical care while in placement is the Comprehensive Medical Examination, or CME. As of January 1, 2009, DCP&P requires that children receive a CME within 30 days of entering placement. A CME can be done by:

- A contracted CME provider
- The child's primary care physician

A CME includes a comprehensive health and developmental history, a comprehensive physical examination, and a mental health screening. While the CME can provide valuable information about a child's medical and physical health, mental health and developmental needs are assessed only through a screening; further mental health assessments will be recommended if there are concerns about the child's behavioral or mental health, or their development.

In some counties, one of the contracted CME providers is the Regional Diagnostic and Treatment Center (RDTC). Also, a CME may be done at an RDTC if the child was sexually abused or severely physically abused.

When the CME is done at one of the RDTCs, the examination may be in the form of a CHEC (a Comprehensive Health Evaluation for Children). A CHEC is a three-part examination – medical, mental health, and neurodevelopmental – usually completed in one day and possibly taking up to 6 hours.

In each case, it is expected that a *CME form*, a physician report, or a comparable comprehensive report (including a *CHEC Report*) will be completed and returned to DCP&P (usually within 14 days of the CME visit). Regardless of the type of CME or who performs it, the report will include recommendations for follow-up care or treatment based on concerns identified during the exam. Please note that we have included examples of a *CME form* and a blank *CHEC Report* in your manual as a reference. These are simply examples because different providers utilize different forms – use of the CME or CHEC forms provided is not a DCF or DCP&P policy requirement.

NOTE: If the child has been a victim of physical abuse, recent sexual abuse, or severe neglect, the child may need immediate consultation with a Regional Diagnostic and Treatment Center (RDTC). DCP&P is responsible for reaching out to the RDTC to arrange for such consultation. This consultation is neither a PPA nor a CME.

Mental Health Screening within 30 days

Every child entering out-of-home placement should undergo a Mental Health Screening within 30 days of entering placement. The purpose of the Mental Health Screening is to identify children with a suspected mental health need and refer those children for a full Mental Health Assessment.

DCF uses three avenues of Mental Health Screening for children in out-of-home placements. These three avenues are outlined in the chart below, as well as the tool that each screener uses, and the timing of the screening.

Screener	Tool	Frequency
CHU Nurse	*Pediatric Symptom Checklist*[1]	• within 14 days of placement • every 180 days after placement

[1] The Pediatric Symptom Checklist is a psychosocial screening tool designed to aid the CHU nurses in recognizing children age 2 years and above with suspected cognitive, emotional, and behavioral problems. It is in the form of a questionnaire and relies on the caregiver's knowledge of the child's behavior over time, as well as changes in behavior.

		• as needed
DCP&P Caseworker	*NJ Mental Health Screening Tool (NJ MHST)*[2]	• within 30 days of placement • every 180 days after placement • as needed
CME Provider	Physician Discretion	At the time of the CME

It is important to note that DCP&P caseworkers are required to conduct Mental Health Screening within 30 days of the child entering out-of-home placement, 180 days thereafter, and as needed until permanency is achieved. This is in addition to Mental Health Screening provided by CHU nurses and CME providers.

It is also important to note, however, that there is no need for a Mental Health Screening if:

- The child has already been referred for a Mental Health Assessment;
- The child is receiving Mental Health services; or
- The child presents with an urgent need for Mental Health services.

Additionally, an initial Mental Health Screening is not needed if the child has had a CHEC exam in place of a standard CME within 30 days of placement (however, the periodic 180 day Mental Health Screening or screening as needed should still be done).

If a Mental Health Screening indicates that a child may have mental health needs, then a full Mental Health Assessment should be recommended by the screener. Also, if there are concerns about a child's mental health status and the child is already engaged in services, the CASA volunteer should work with DCP&P, and the Court if needed, to ensure appropriate intervention for the child.

Finally, there are situations in which a child's history or circumstances would dictate that the child be referred directly for a Mental Health Assessment. Thus, a DCP&P caseworker may refer a child for a Mental Health Assessment without having to go through the Mental Health Screening. For example, DCP&P recommends that children experiencing one or more of the following be referred for a Mental Health Assessment:

- Children entering placement with mental health histories (not currently in treatment)
- Children with a history of physical and/or sexual abuse (but not currently in treatment)

[2] The NJ MHST was developed specifically for child welfare workers to assist them with recognizing a child with a suspected mental health need. The caseworker answers the questions using their skills of observation of the child's current behavior and knowledge of the child's current history.

- Children whose primary caretaker has a history of mental illness
- Children with a history of multiple changes in placement
- Children with a history of running away from placements.

Health Passport

The Health Passport is a multi-page form containing child health information to the extent that it is available and known to DCP&P. The Health Passport form is completed by the Child Health Nurse and updated regularly. It is designed to follow the child through his or her entire time in placement.

The child's Health Passport is to be shared with the child's primary care provider (or medical home), DCP&P caseworker, biological parents, and resource parents or other caregivers. As a child gets older, they should be encouraged to take a more proactive role in their healthcare and should become familiar with their own Health Passport. If they age out of placement, the youth should receive his or her Health Passport. A sample *Health Passport and Placement Assessment* can be found in this manual.

On-going Health Care for Children in Placement

Once the initial screenings and evaluations are completed, children in placement are entitled to the following on-going health care, which is coordinated through the CHUs in each of the local DCP&P offices:

- Routine preventive medical care in the form of Early and Periodic Screening Diagnostic and Treatment (EPSDT) examinations (well-child visits) in accordance with the periodicity schedule in Chapter 3 of this manual
- Semi-annual Dental Exams for any child aged 1 and over, as well as any other dental care needed
- Up-to-date immunizations (as discussed in Chapter 3 of this manual)
- Maintenance/update of Health Passport
- Appropriate follow-up care to address health care needs

As mentioned in Chapter 1, every child in out-of-home placement should have a Health Plan. The Health Plan outlines routine healthcare services that are to be provided (such as regular well-care, dental, and vision care). Additionally, for children with special medical needs, the Health Plan should outline those special needs and address how they will be met, as well as outline the routine healthcare services that are (or should continue to be) provided. The Health Plan is contained in the *Pediatric Nursing Report*, which is part of the Health Care Case Management Record described below and contained in this Manual.

Child Health Unit Medical Records

A Health Care Case Management (HCCM) Record is organized and maintained by the CHU in each DCP&P Local Office for each child in placement who is receiving health care case management services. The HCCM Record contains documentation and information pertaining to health care case management of the child, as well as pertinent health records obtained by DCP&P and the CHU. Specifically, the HCCM will contain *Pediatric Nursing Reports* which are completed by the CHU nurses and which document the child's health needs and contain the Health Plan, and a *Contact Sheet Form* which is simply a form upon which CHU nurses and DCP&P caseworkers memorialize their contacts with regard to the child's health. The HCCM may also contain case notes and medical records.

CASA volunteers should request to review the HCCM Record at the same time that they request review of the DCP&P case file.

Points of Advocacy for CASA

- When a child enters care, information about the child's and family's health history is often limited. Upon appointment, the CASA should gather as much information as possible and communicate any findings to the DCP&P caseworker, requesting that the information be included in the child's records and passed along to the CHU.
- CASA can play an important role in ensuring that the policies and protocols in place regarding the required examinations and assessments (PPAs and CMEs) are being followed, and that the child is receiving all needed services at the appropriate times.
- CASA can play a critical role in facilitating open lines of communication among the various professionals charged with completing different screenings and assessments and providing care for the child, and ensuring that the recommended plan of care meets the child's needs.
- Because CHU's are contracted service providers, CASAs should understand that there may be communication challenges as with any other service provider. CASAs play an important role in helping overcome any such challenges that might arise.
- CASAs should be sure to request a review of the child's full HCCM Record while reviewing the child's DCP&P case file. Before looking at the Medical Record, the CASA should become familiar with the forms and descriptions as described in this chapter. While the type and content of records vary for each child, the documents in this chapter provide a basis for what CASAs might expect to find.
- CASAs should review the child's PPA as it is the first medical assessment made when a child is taken into care and provides a snapshot of the child's condition upon entering care. The PPA may contain important

findings about abuse or neglect, information establishing the child's status or condition at the time of placement, and information about any health issues that require immediate attention.

- CASAs should ascertain whether the caregiver was made aware of any issues found as a result of the PPA (if the caregiver is still the same) and whether any follow-up was or needs to be done.
- CASAs should find either a CME or CHEC form/report in the child's HCCM Record. (CHEC reports are done only on cases going through the Regional Diagnostic and Treatment Centers (RDTCs)). Ideally, this form should be filled out completely. Depending on the child's health needs, it may be necessary to follow up with the child's healthcare provider(s).
- CASAs should ensure that every child has had a Mental Health Screening unless the child: (1) has already been referred for a Mental Health Assessment; (2) is receiving Mental Health services; (3) presents with an urgent need for mental health services; or (4) has had a CHEC exam in place of a CME.
- CASAs should be sensitive to the trauma of placement and any resulting mental health needs. CASAs should advocate for Mental Health Assessments based on the child's needs and any perceived mental health issues.
- If the child has had a Mental Health Assessment, the CASA should determine whether s/he is receiving all recommended mental health services.
- If the child is on medications to treat a mental health need, the CASA should review the psychotropic medication treatment plan and be aware of and help to address any challenges that impact implementation of the plan.
- CASAs can help ensure that, as a child gets older, s/he is encouraged to take a more proactive role in their own healthcare and begin to become familiar with the contents of their own Health Passport.
- When a CASA is assigned to a child who has been in placement for several months or more, the information contained in the PPA and CME may not be current. The CASA should review the child's Health Passport as well as documentation of the child's most recent well-child visits in order to get an accurate view of the child's current health status.

Manual Documents:

- Health Care Case Management (HCCM) flowcharts
- Pre-Placement Assessment Form/Report
- CME Exam Form (example only)
- CHEC Exam Form (example only
- NJ Mental Health Screening Tools (0-5 years; 6 years and up)
- Pediatric Symptom Checklist
- Health Passport and Placement Assessment
- Pediatric Nursing Report (part of the Health Care Case Management File)
- Contact Sheet Form (part of the Health Care Case Management File)

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Child Health Program

Health Care Case Management

Child Enters Out of Home Placement

PPA completed by CHU nurse or Community Provider

- **NO** Notify CNC for documentation
  - Review / Share with RP and CP&P staff
    - Enter PPA into NJS
- **YES** Review/Share with RP and CP&P staff
  - Enter PPA into NJS

Health Passport and Placement Assessment

- Obtain history from PPA, Health Focus, NJIIS or medical records
- Assess and assign acuity level within 72 hours of notification of placement
- Attend 72 hour preplacement meeting to obtain health history from parents
- Begin and share with CP&P staff and RP within 5 days of placement
- Update after 30 days and quarterly Share with CP&P staff and RP

CME Schedule appointment within 30 days of placement

- Notify CP&P staff and RP of date of CME
- Send all available medical records to CME Provider, prior to exam
- CME completed and entered into NJS
- CME findings reviewed
- Child scheduled for follow up care

Home Visit

- Resource providers contacted and appointment scheduled
- Prepare education materials for home visit
- Home visit made within 2 weeks of notification of placement
- Screen child using PSC according to CHP Policy
- Document home visit on PNR within 2 weeks of visit

Ongoing Health Care Case Management

Review Immunization Record

- Not Up-to-Date Facilitate PMD visits to update immunizations
  - At end of quarter document status in NJS
- Up-to-Date Document status in NJS quarterly

Well Child Care

- Review record and Safe Measures for need
- Schedule visit according to need and EPSDT guidelines
- Send for collaterals and review finding
- Facilitate follow up care recommended
  - Send for collaterals and review finding, monitor that all follow up visits are kept
- Enter exam into NJS

Semi-Annual Dental Care

- Review record and Safe Measures for need
- Facilitate exam
- Send for collaterals and review finding
- Enter exam into NJS

Home Visit

- Assess frequency of home visit
- Schedule home visit and prepare for visit
- Screen child using PSC according to CHP Policy
- Document home visit on PNR within 2 weeks of visit

Behavioral Health Care Case Management

Mental Health Screening

- **YES** Completed by HCCM/CME Refer for Mental Health Assessment as indicated
  - Completed by HCCM / CME Referral made
  - CHU referred for CHEC Review findings
  - Enter Mental Health Screening into NJS
- **NO** Not completed per CHP Policy
  - Child < 2 years of age
  - Child Receiving Mental Health Treatment Obtain record of Mental Health Evaluation
  - Not completed Need identified Referral made

Mental Health Assessment

- Conference screening findings with CP&P staff
- Assist with scheduling Mental Health Assessment
- Obtain report and review finding
- Assist with scheduling child for recommended services
- Enter Mental Health Assessment into NJS

Mental Health Treatment Services

- Assist with scheduling child for recommended services
- In treatment note provider, appointments, treatment modalities, treatment plans, and child's progress
- Review record and monitor that child is receiving recommended services
- Enter services child is receiving into NJS

Medication Monitoring

- Maintain list of current psychotropic medications the child is on
- Maintain copy of current consents and current treatment plan
- Obtain record of Mental Health evaluation
- Record any adverse effects, side effects, or medication interaction child may experience while on a medication
- Assess whether medication meets CP&P prescribing parameters
- Facilitate care to ensure monitoring guidelines are met
- Consult Psych APN as needed

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Child Health Program

Health Care Case Management for Youth Transitioning into Adulthood

Youth Ages 14 though 21 Years

In collaboration with Case Worker, Meet Youth, Establish and Build a Trusting Relationship

Assist youth with meeting and understanding their basic health care needs

Immunizations

- Review record and discuss the role immunizations play in becoming a healthy adult

Adolescent Health Care

- Assess records for need
- Assist with scheduling visits and prepare youth
- Send for collateral and review finding with youth; refer back to PMD if clarification needed
- Discuss follow up care recommended and assist with scheduling
- Teach importance of ongoing Preventive Health Care
- Send for collaterals, review finding and monitor that all follow up visits are kept

Dental Care

- Assess records for need
- Assist with scheduling visits and prepare youth
- Send for collaterals and review finding with youth
- Teach importance of ongoing Dental Health Care
- Discuss follow up care recommended and assist with scheduling

Assist youth living with chronic health or mental illness

Specialty Care

- Assist with scheduling necessary visits and prepare youth for visit
- Assess the youth's understanding of their condition
- Reinforce education provided to youth by specialist on condition
- Empower youth to understand and question all aspects of their care

Home Visit

- Coordinate home visit with case worker and prepare
- Assess youth's adjustment to living arrangement
- Screen youth for mental health care needs
- Provide anticipatory guidance to empower youth to make healthy decisions

Health Passport

- Educate on the role of the health passport
- Review passport
- Encourage youth to maintain health care records

Health Care Providers

- Encourage youth to choose providers knowledgeble in meeting their needs
- Educate youth on questions to ask providers about their health

Future Development Planning

- **Case Conference:** Case Conference with case worker and youth to discuss future
- **Education:** Review goals and support Continuing education and choices.
- **Employment:** Discuss current and future plans. Encourage youth to participate in training offered
- **Housing:** Discuss life long need for stable housing
- **Adult support:** Discuss developing adult supportive relationships
  - **Peer Support:** Discuss peer choices and decisions made.

A Child Health Collaboration between DCF/CP&P and François-Xavier Bagnoud Center within Rutgers School of Nursing

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Health Care Case Management of Youth as They Age Out of Foster Care

Child Health Program

In collaboration with case worker meet youth , establish and build a trusting relationship

Ensure youth's ability to navigate the Health Care System

Access to Health Care:
Ensure continuous health insurance coverage

- Assist youth with enrollment in Medicaid under MEYA
- Assist with completion of forms if requested
- Document Medicaid number on Health Passport

Health Care Proxy:
Encourage youth to assign a Health Care Representative

- Provide education on the Health Care Proxy
- Assist with completion of forms if requested
- Ensure youth has original health proxy document and that a copy has been shared

Health Passport:
History that has been gathered and tracked while youth is in placement

- Meet youth and review Health Passport and Immunization Record
- Document sharing in HCCM record

Preventative Care:
Promote responsibility for health care

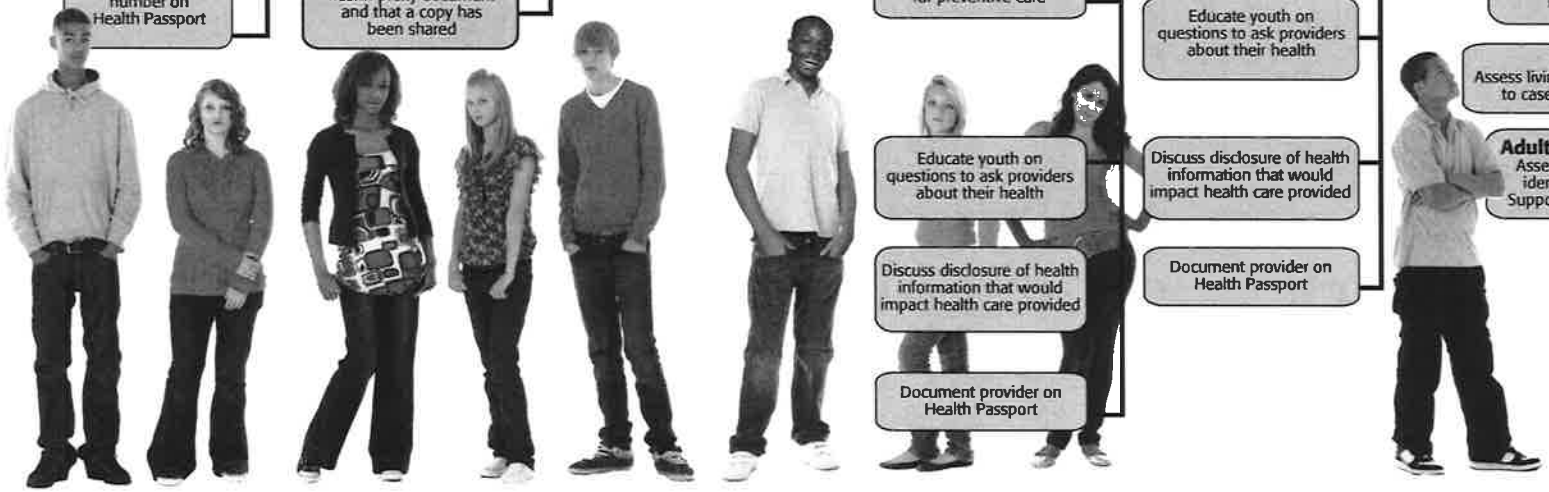
- **Assist youth with identifying providers**
- If requested assist with scheduling appointments
- Educate youth on the need for preventive care
- Educate youth on questions to ask providers about their health
- Discuss disclosure of health information that would impact health care provided
- Document provider on Health Passport

Special Needs:
Chronic Health and Behavioral Health Care Needs

- Assist youth with identifying specialists or mental health providers
- If requested assist with scheduling appointments
- Educate youth on questions to ask providers about their health
- Discuss disclosure of health information that would impact health care provided
- Document provider on Health Passport

Future Goals:
In collaboration with case worker promote independence

- Case conference with youth and case worker future plans
- **Education:** Review goals and support case worker in developing career goals
- **Employment:** Discuss youth's ability to financially support self. Consult worker if support need is reported
- **Housing:** Assess living arrangements. Refer to case worker if unstable.
- **Adult Support Systems:** Assess whether youth has identified a caring adult. Support and encourage one.
- **Peer Support:** Discuss peer choices and decisions made.



A Child Health Collaboration between DCF/DCP&P and François-Xavier Bagnoud Center within Rutgers School of Nursing

9/1/15

CP&P 11-3
(rev. 10/2007)

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
Pre-Placement/Re-Placement Assessment

Case ID #

☐ Pre-placement ☐ Re-placement
Date of Assessment

CHILD ☐ M ☐ F	First	Last	Date of Birth	**INSURANCE** Medicaid Number HMO Other Insurance
CP&P WORKER	First	Last	Contact Number	CP&P Local Office
SPRU WORKER	First	Last		County SPRU Operation
HEALTH PROFESSIONAL	First	Last	Title / Position	Location

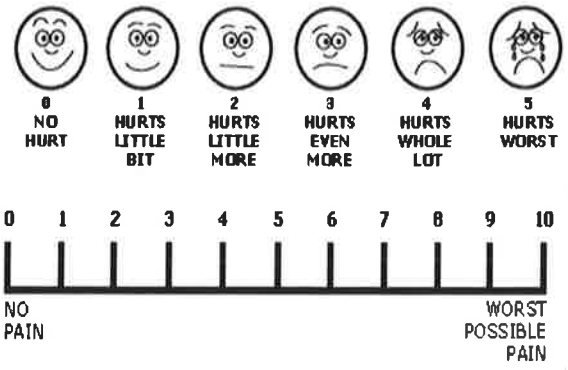
CURRENT COMPLAINTS	☐ None	☐ Non-verbal child	☐ As follows
PAST MEDICAL HISTORY	☐ Unknown	☐ None	☐ As follows
PAST SURGICAL HISTORY	☐ Unknown	☐ None	☐ As follows
IMMUNIZATION HISTORY	☐ See attached records	☐ Not available at time of assessment	
MEDICATIONS	☐ Unknown	☐ None	☐ As follows
ALLERGIES	☐ No known drug allergies	☐ No known food allergies	☐ Other allergies

Additional information (Maximum 200 characters)

Does child complain of pain? Yes ☐ No ☐ Non-verbal ☐

Describe pain (Maximum 50 characters)

Wong Faces Score ____ or Linear Graph Score ____



Review of Systems

General	☐ none	☐ chills	☐ fatigue	☐ fever		
Head	☐ none	☐ dizziness	☐ headache	☐ head injury		
Eyes	☐ none	☐ blurred vision	☐ glasses/lenses	☐ strabismus		
Ears	☐ none	☐ decreased hearing	☐ discharge	☐ pain		
Nose	☐ none	☐ congestion	☐ rhinorrhea			
Throat	☐ none	☐ hoarse	☐ sore			
Respiratory	☐ none	☐ cough	☐ shortness of breath	☐ wheeze		
Cardiovascular	☐ none	☐ chest pain	☐ rapid heart rate	☐ syncope		
Gastrointestinal	☐ none	☐ constipation	☐ diarrhea	☐ emesis	☐ encopresis	
Genitourinary	☐ none	☐ discharge	☐ dysuria	☐ enuresis	☐ trauma	
Musculoskeletal	☐ none	☐ swelling	☐ trauma			
Neurological	☐ none	☐ tingling	☐ weakness			
Skin	☐ none	☐ jaundice	☐ pruritis	☐ rash		

Additional information (Maximum 250 characters)

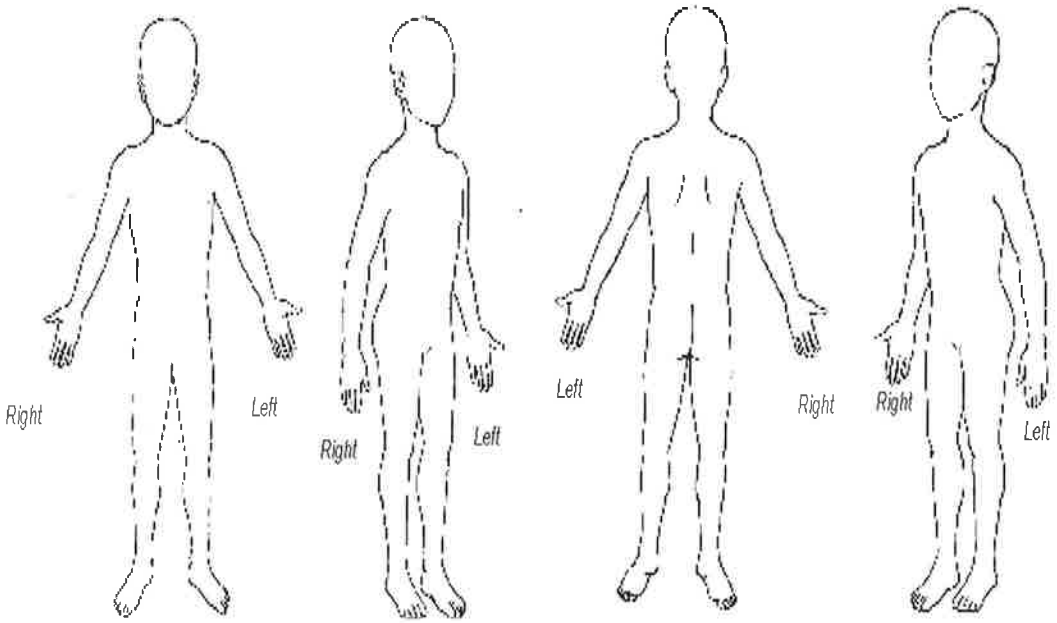
Physical Assessment

Temp	Method	HR	RR	BP	BMI / Percentage

HT (cm) / Percentage	WT (kg) / Percentage	HC (cm) / Percentage

General	☐ well-appearing	☐ lethargic	☐ inconsolable			Other
Head	☐ normal	☐ bruising	☐ hair loss	☐ lice / nits	☐ scaling	
Eyes	☐ normal	☐ discharge	☐ erythema	☐ injection	☐ icterus	
Ears	☐ normal	☐ discharge	☐ foreign body	☐ inflamed TM		
Nose	☐ normal	☐ foreign body	☐ rhinorrhea			
Throat	☐ normal	☐ cavities	☐ white patches	☐ ulcers		
Respiratory	☐ normal	☐ crackles	☐ decreased breath sounds	☐ stridor	☐ wheeze	
Cardiovascular	☐ normal	☐ murmur				
Gastrointestinal	☐ normal	☐ guarding	☐ mass	☐ rebound	☐ tender	
Genitourinary	☐ normal	☐ child refused	☐ external injury	☐ rash	☐ testicular mass	
Extremities	☐ normal	☐ deformity	☐ swollen joint	☐ tender		
Neurological	☐ normal	☐ abnormal gait	☐ focal deficit	☐ weakness		
Skin	☐ normal	☐ rash	☐ bruising/marks injury (see body diagrams)			

Additional information (Maximum 250 characters)



☐ **None noted**

Description of Injuries (Maximum 500 characters)

Assessment

To the best of my knowledge, based upon the above history and physical and all information available at this time, this child is		
1. Free from communicable illness	☐ **Yes**	☐ **No**
2. Free from acute injury requiring immediate medical attention	☐ **Yes**	☐ **No**
3. Free from acute medical illness requiring immediate medical attention	☐ **Yes**	☐ **No**
4. In need of special transportation (If so specify needs below in plan/follow-up below	☐ **Yes**	☐ **No**

Assessment Summary (Maximum 500 characters)

Plan / Recommendation for Follow-Up (Maximum 1500 characters)

Name, Title, and Date (please print and sign)

Provider Stamp

Signature

Date **Time**

DISTRIBUTION:

ORIGINAL	**WORKER**
COPY	**HEALTH CARE PROFESSIONAL**
COPY	**CAREGIVER**
EMAIL	**WORKER**
EMAIL	**LO NURSE**

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

Department of Children and Families
Division of Child Protection and Permanency
Comprehensive Medical Examination (CME)
FINAL REPORT PART I –MEDICAL HISTORY, RECORD REVIEW

TO BE COMPLETED BY CHILD HEALTH UNIT

MATERIALS PROVIDED TO THE CME PROVIDER TO SUPPORT THE OPINIONS & RECOMMENDATIONS IN THIS REPORT

- ☐ Birth Records
- ☐ Immunization Records
- ☐ Hospital Records
- ☐ DCP&P History
- ☐ Imaging Studies
- ☐ Specialty Consultations
- ☐ Growth Charts
- ☐ ER Visits
- ☐ Primary Care Provider Records
- ☐ School Information
- ☐ Other: _____
- ☐ Other: _____

BRIEF NARRATIVE OF RELEVANT CHILD HISTORY TO GUIDE THE MEDICAL EXAMINATION:

BIRTH HISTORY (child < 6 years) ☐ **No information available** ☐ **Not applicable (child > 6 years)**

- ☐ Prenatal Care for Mother
  - ☐ Prenatal Hep B
  - ☐ Prenatal HIV
  - ☐ Prenatal RPR
  - ☐ Prenatal Other: _____
- ☐ Prenatal Complications (*specify below*)
- ☐ Neonatal Complications (*specify below*)
- ☐ Neonatal Immunizations (*specify below*)
- ☐ Birth Hosp: _____Ht. ____ cm
- ☐ Delivery Complications (*specify below*)
  - ☐ Vaginal ☐ C Section
- ☐ Gestational Age _____
- ☐ Birth Wt. _____ H.C.____ cm

COMMENTS: _____

NEONATAL TESTING ☐ **No information available** ☐ **Not applicable (child > 6 years)**

Newborn Screen	HIV (date:)	Drug Screening	OAE/Hearing, Screen	Other
☐ abnormal	☐ positive	☐ positive _____	☐ failed	_____
☐ normal	☐ negative	☐ negative	☐ passed	_____
☐ unk	☐ unk ☐ not done	☐ unk ☐ not done	☐ unk ☐ not done	_____

COMMENTS: _____

DEVELOPMENT: IDENTIFY ANY KNOWN CONCERNS AND DELAYS

CONCERNS: _____

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

CURRENT SERVICES: _____

SCHOOL HISTORY **GRADE:** _____

CURRENT PLACEMENT: _____

SPECIAL SERVICES/CST: _____

BEHAVIORAL HEALTH: IDENTIFY ANY KNOWN CONCERNS AND TREATMENTS, INCLUDING SERVICE PROVIDER

CURRENT SERVICES: _____

ADOLESCENT SOCIAL RISK FACTORS (BRIEF NARRATIVE ON FAMILY RELATIONSHIPS, ADJUSTMENT TO PLACEMENT , PEER RELATIONSHIPS, ALCOHOL, DRUG OR TOBACCO USE, SEXUAL ORIENTATION, SEXUAL ACTIVITY, PREVENTION OF STDS AND FAMILY PLANNING, HOBBIES AND CAREER PLANS) _____

PERTINENT FAMILY MEDICAL HISTORY: ☐ NO INFORMATION AVAILABLE

_____

Hospitalizations/Surgeries

☐ yes *(list)* ☐ no

1. _____

Immunizations (Attach copies of records if available)

☐ up to date
☐ delayed
☐ records not available

HEALTH MAINTENANCE/EPSDT

DENTAL CARE	VITAMINS & FLUORIDE	GROWTH/NUTRITION	DEVELOPMENT	BEHAVIOR
☐ AGE APPROPRIATE	☐ AGE APPROPRIATE	☐ AGE APPROPRIATE	☐ AGE APPROPRIATE	☐ AGE APPROPRIATE
☐ REFER	☐ N/A	☐ AT RISK	☐ AT RISK	☐ AT RISK

ALLERGIES:

☐ NO
☐ NONE KNOWN
☐ YES

MEDICATIONS (PLEASE LIST):
FOOD:
ENVIRONMENTAL:

ACTIVE DIAGNOSES (PLEASE LIST): _____

CURRENT MEDICATIONS (LIST) AND DOSES: _____

CURRENT SPECIALISTS INVOLVED: _____

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

SPECIAL SERVICES:

- ☐ PT
- ☐ OT
- ☐ SPEECH
- ☐ MENTAL HEALTH
- ☐ OTHER

CHILD HEALTH UNIT STAFF SIGNATURE: _____
DATE: _____

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

Department of Children and Families
Division of Child Protection and Permanency
Consultation: Comprehensive Medical Examination/ Well Child Visit
FINAL REPORT PART II: CLINICIAN REPORT

DATE OF VISIT: _____ **CHILD ACCOMPANIED TO VISIT BY:** _____

INFORMATION PROVIDED BY: ☐ PATIENT ☐ FOSTER PARENT ☐ DCP&P WKR ☐ OTHER: _____

T _____ **Wt.** _____ kg (____)% **Hearing** ☐ pass ☐ fail ☐ unable to complete

HR _____ **Ht.** _____ cm (____)% **Vision** ☐ pass ☐ fail ☐ unable to complete

RR _____ **HC** _____ cm (____)% **Pain** ☐ no ☐ yes *(specify)* _____

BMI _____ **Allergies** ☐ none ☐ yes *(list)* _____

BP _____ _____

A. MEDICAL CONCERNS _____

B. REVIEW OF SYSTEMS CHECK BOX IF NORMAL; SPECIFY IF ABNORMAL

- ☐ **SKIN:** _____
- ☐ **HEENT:** _____
- ☐ **HEMATOLOGIC:** _____
- ☐ **CARDIAC:** _____
- ☐ **RESPIRATORY:** _____
- ☐ **GI:** _____
- ☐ **GU:** _____
- ☐ **GYN/MENSTRUAL:** _____
- ☐ **SKELETAL/MUSC:** _____
- ☐ **NUTRITION:** _____
- ☐ **DEVELOPMENT:** _____
- ☐ **NEURO/PSYCH:** _____

C. PSYCHOSOCIAL ISSUES: _____

D. PERTINENT FAMILY HISTORY: _____

E. ADDITIONAL COMMENTS: _____

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

GENERAL APPEARANCE:

HEAD:

EYES/VISION:

EARS/NOSE/THROAT:

DENTAL:

NECK/NODES:

CHEST/LUNGS:

BREASTS:

HEART/PULSE:

ABDOMEN:

GENITALIA:

TANNER STAGE:

EXTREMITIES:

BACK:

SKIN:

NEUROLOGIC:

DEVELOPMENTAL SCREEN SPECIFY SCREEN: ☐ DENVER ☐ AGES AND STAGES ☐ OTHER _____

☐ AGE APPROPRIATE ☐ FAIL-GROSS MOTOR; ☐ FAIL-LANGUAGE;
☐ FAIL-FINE MOTOR-ADAPTIVE; ☐ FAIL-PERSONAL-SOCIAL

MENTAL HEALTH SCREEN, SPECIFY SCREEN: ☐ PSC 35 (AGES 2 & ABOVE) ☐ OTHER _____

☐ COMPLETED-NO REFERRAL REQUIRED ☐ COMPLETED-REFERRAL REQUIRED
☐ NOT COMPLETED-RECEIVING MENTAL HEALTH SERVICES ☐ UNABLE TO COMPLETE

COMMENTS AND RECOMMENDATIONS (INCLUDE IMMUNIZATIONS GIVEN, TESTS ORDERED, MEDICATIONS PRESCRIBED, ACTION NEEDED)

RN OR MD SIGNATURE: _____
DATE: _____

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

Department of Children and Families
Division of Child Protection and Permanency
Consultation: Comprehensive Medical Examination (CME) -- Medical
FINAL REPORT PART III - SUMMARY

CLINICAL FINDINGS AND RECOMMENDATIONS

MEDICAL: _____

A. **WELL INFANT/CHILD/ADOLESCENT** YES ☐ NO ☐
B. **NORMAL GROWTH** YES ☐ NO ☐
C. **CONCERNS:** _____

LAB REPORTS/RESULTS: _____ **SPECIFY TEST**

A. WITHIN NORMAL LIMITS ☐ ABNORMAL ☐
B. WITHIN NORMAL LIMITS ☐ ABNORMAL ☐
C. WITHIN NORMAL LIMITS ☐ ABNORMAL ☐

DEVELOPMENTAL: _____

A. **NORMAL DEVELOPMENT SCREEN** YES ☐ NO ☐
B. **PLEASE SPECIFY AREAS OF CONCERN**

MENTAL HEALTH: _____

A. **NORMAL MH SCREEN** YES ☐ NO ☐
AREAS OF CONCERN? PLEASE SPECIFY: _____

NUTRITIONAL CONCERNS: YES ☐ NO ☐
PLEASE SPECIFY: _____

IMMUNIZATIONS ☐ UP-TO-DATE PRIOR TO CME VISIT ☐ ADDITIONAL IMMUNIZATIONS STILL REQUIRED (SEE PLAN OF CARE)

☐ **GIVEN DURING CME VISIT:**

☐ DTaP	☐ Tdap	☐ TD	☐ Prevnar	☐ Hib
☐ MMR	☐ Varicella	☐ Hepatitis B	☐ Rotavirus	☐ IPV
☐ Influenza	☐ Meningococcal	☐ HPV	☐ Other	

COMMENTS: _____

SCREENING TESTS ORDERED VISIT:

☐ CBC (<6yrs. & adol. females)	☐ Lead	☐ Hepatitis (HBsAG)
☐ Sickle Cell Screen	☐ HIV (at Risk)	☐ UA (>2yrs.)
☐ Hepatitis C Antibody Screen	☐ Cholesterol	☐ Other _____
☐ Urine TOXICOLOGY SCREEN	☐ Urine for Pregnancy	
☐ Urine for STD Screen	☐ PPD – Date to Read: _____	

Child's Name (Last name, First name):	NJ SPIRIT Person #:		
	NJ SPIRIT Case #:		
	DCP&P Local Office:		
Case Name:	DOB:	Age Today: Years Months	Exam Date:
[ ]1st Visit/Comprehensive Medical Exam			
Medicaid #:	Medicaid HMO:		

ACTIVE DIAGNOSES (LIST)

_____

CHILD'S CURRENT MEDICATION (LIST) **NO MEDICATIONS (PLEASE CIRCLE IF NO MEDICATIONS)**

MEDICATION	DOSE	INDICATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANY CHANGES IN MEDICATION? YES ☐ NO ☐

PLEASE SPECIFY: _____

AREA/PROBLEM	ACTION TO BE TAKEN	RESPONSIBILITY PARTY	TIMELINE
MEDICAL	_____	_____	_____
DENTAL	_____	_____	_____
DEVELOPMENTAL	_____	_____	_____
MENTAL HEALTH	_____	_____	_____
FAMILY PLANNING	_____	_____	_____
OTHER	_____	_____	_____

ANTICIPATORY GUIDANCE

AGE: ☐ 0-2 YRS ☐ 2-6 YRS ☐ 7-12 YRS ☐ 13-18 YRS

☐ UNIVERSAL PRECAUTIONS	☐ NUTRITION	☐ EXERCISE	☐ FLUORIDE
☐ SMOKE DETECTORS	☐ DENTAL CARE	☐ SIDS PREVENTION	☐ MOTOR VEHICLE SAFETY
☐ DRUG/TOXIC STORAGE	☐ UV PROTECTION	☐ STAIRWAY GATES	☐ BIKE HELMETS
☐ POISON CONTROL #	☐ WINDOW GUARDS	☐ PASSIVE SMOKE	☐ STD/HIV
☐ ABUSE PREVENTION	☐ TOBACCO	☐ MENARCHE	☐ ETOH/DRUGS
☐ PREGNANCY	☐ VIOLENCE/GUNS	☐ MATCHES STORAGE	☐ WATER SAFETY
☐ SAFE SLEEP			

RN OR MD SIGNATURE: _____

DATE: _____

NAME/CREDENTIALS: _____

PATIENT LABEL **MD2-4**

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 4 MONTHS TO 5 YEARS

PSYCHOLOGICAL TESTING RESULTS AND INTERPRETATION

CONDUCTED BY: _____ DATE: _____

A. AGES AND STAGES QUESTIONNAIRE (ASQ)

Completed By: _____ Relationship: _____

Area Scores: Questionnaire Used: ____ months

Communication: _____	Cutoff: _____	Within Normal Limits?	☐Y ☐N
Gross Motor: _____	Cutoff: _____	Within Normal Limits?	☐Y ☐N
Fine Motor: _____	Cutoff: _____	Within Normal Limits?	☐Y ☐N
Problem-Solving: _____	Cutoff: _____	Within Normal Limits?	☐Y ☐N
Personal-Social: _____	Cutoff: _____	Within Normal Limits?	☐Y ☐N

COMMENTS: _____

_____

B. AGES AND STAGES QUESTIONNAIRE: SOCIAL-EMOTIONAL (ASQ-SE)

Completed By: _____ Relationship: _____

Questionnaire Used: ____ months

Total ASQ-SE Score: _____ Cutoff: _____ Within Normal Limits? ☐Y ☐N

COMMENTS: _____

_____

C. CHILD BEHAVIOR CHECKLIST (CBCL) FOR AGES 1½ TO 5

Completed By: _____ Relationship: _____

T-Scores: *(Mean= 50, standard deviation= 10)*

		I. Emotionally Reactive:	_____
Internalizing:	_____	II. Anxious/Depressed:	_____
		III. Somatic Complaints:	_____
Externalizing:	_____	IV. Withdrawn:	_____
		V. Sleep Problems:	_____
Total Score:	_____	VI. Attention Problems:	_____
		VII. Aggressive Behavior:	_____

INFO FROM LANGUAGE SURVEY: _____

_____

COMMENTS: _____

_____

_____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 4 MONTHS TO 5 YEARS

CARETAKER INTERVIEW

WITH: _____

CONDUCTED BY: _____ DATE: _____

A. Please tell me about this child. (For infants and toddlers in particular, include sleeping and eating concerns, general temperament, and attachment)

_____
_____
_____
_____
_____

B. What information were you given about (child)? (Include child's attributes, family history, substance abuse concerns, drug exposure during pregnancy, etc.)

_____
_____
_____
_____
_____

C. Report of high-risk/ problem behaviors.

- Irritable/Crying too much
- Inconsolable/Can't be calmed
- Sleeping Problems
- Eating/Feeding Problems
- Aggression/Fighting
- Lying
- Sexual Acting Out
- Cruelty (to others, animals)
- Bullying
- Stealing
- Property Damage
- Self-Injury

_____
_____
_____
_____
_____

D. Report of observed strengths/ positive qualities.

- Education/Learns new things
- Takes pleasure in activities
- Optimism/Resilience
- Talents/Special Interests
- Self-regulation
- Interpersonal skills

_____
_____
_____
_____

PATIENT LABEL

E. Caretaker's view on child's understanding of placement.

- What does the child understand about the reason for placement?
- What have you told or explained to the child? What has the child told you?
- Do you think that the child has a good understanding of why he/she is in foster care?

F. Information regarding child's contact with biological family members.

- Has child asked to see or speak to biological parents? Siblings? Other family members?
- Has child had any contact with parents? Siblings? Other family members?
- How did child react to this contact?

G. Account of child's adjustment to foster home (and foster family's adjustment to child).

- How has the child adjusted to his or her new home?
- How have you (and your family) adjusted?
- Is there anything (support services, therapy, etc.) that could help make the adjustment easier?

H. Overall, how would you rate your feeling about having this child in your home?

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

I. Overall, how would you rate the child's adjustment to your home/to foster care?

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

J. Additional Comments:

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 4 MONTHS TO 5 YEARS

CHILD INTERVIEW

CONDUCTED BY: _____ DATE: _____

A. Mental status (include activity level, affect, mood, relatedness, orientation x3, appearance, etc).

- What is your name? Age? Birthday (including year)? Address/phone number?
- Do you go to school? Do you like school? What is your favorite subject?
- Who is in your family? Do you have any brothers or sisters?
- Who are these people (i.e., differences between foster parents, biological siblings, etc.)?
- Three wishes?

_____
_____
_____
_____
_____

B. Emotion management.

- What kinds of things make you mad? At your old home? At your foster home?
  - Sad? At your old home? At your foster home? Glad? Scared?
- What do you do when you get very mad? Sad? Glad? Scared?
- What do you do to make yourself feel better?
- Do you talk to anyone about it? Who? Do they make you feel better?

_____
_____
_____
_____
_____

C. Child's report of high-risk or problem behaviors.

Did you/ do you ever:

- Lie to someone?
- Have nightmares?
- Hurt animals?
- Play with matches? Set fires?
- Think about hurting yourself? (Or, hurt yourself?)
- Think about hurting someone else? (Or, hurt someone else?)
- Get into fights? With who?
- Take something from someone that wasn't yours?
- If you did something wrong at your old house, what happened?

_____
_____
_____
_____
_____

PATIENT LABEL

(Attempt the following questions with children ages 4 and over)

D. Child's understanding of foster care system and reason for placement.

- How come you don't live with your biological parents/family?
- Did something happen before you moved to your new house? What happened?
- Why do you think you weren't allowed to stay in your old house? Who decided that?
- Who told you that you weren't allowed to stay there anymore? What else did they tell you?

E. Child's sense of safety (in both past and current placements).

- Did anyone at your old house ever yell at each other? Hurt each other? (Who? Why?)
    - Touch you in a way that made you uncomfortable?
- Did the police ever come to your old house?
- What do you miss most about your old house?
- Do you visit with your Mother/Father/siblings/other relatives?
- Do you like seeing them? Are you sad when your visit is over?

- Does anyone at your foster home ever yell at each other? Hurt each other? (Who? Why?)
    - Touch you in a way that made you uncomfortable?
- How do you feel about living in your foster home? Do you like your foster family?
- What about your foster family do you like (or dislike)? How are they different from your other family?

F. Child's rating of his/her adjustment to foster placement:

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

G. Additional comments:

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 4 MONTHS TO 5 YEARS

MENTAL HEALTH SUMMARY AND RECOMMENDATIONS

TESTING SUMMARY: _____

SUMMARY: _____

RECOMMENDATIONS: _____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 6 TO 18 YEARS

PSYCHOLOGICAL TESTING RESULTS AND INTERPRETATION

CONDUCTED BY: _____ DATE: _____

A. KAUFMAN BRIEF INTELLIGENCE TEST, 2ND EDITION (KBIT-2)

	Standard Score*	Percentile Rank	Descriptive Level
Verbal Scale:	_____	_____	_____
Nonverbal Scale:	_____	_____	_____
Composite:	_____	_____	_____

** Mean = 100, standard deviation = 15*

COMMENTS: _____

_____

B. CHILDREN'S DEPRESSION INVENTORY (CDI)

T-Scores: *(Mean = 50, standard deviation = 10)* *For ages 7 and older*

	T-Score	Descriptive Guideline
Total CDI Score:	_____	_____
Negative Mood:	_____	_____
Interpersonal Problems:	_____	_____
Ineffectiveness:	_____	_____
Anhedonia:	_____	_____
Negative Self Esteem:	_____	_____

COMMENTS: _____

_____

C. TRAUMA SYMPTOM CHECKLIST FOR CHILDREN (TSC-C)

T-Scores: (*Mean= 50, standard deviation= 10)* *For ages 8 to 16*

Validity Scales		Clinical Scales			
Underresponse:	_____	Anxiety:	_____		
Hyperresponse:	_____	Depression:	_____		
		Anger:	_____		
		Posttraumatic Stress:	_____	Overt Dissoc:	_____
		Dissociation:	_____	Fantasy:	_____
		Sexual Concerns:	_____	Preoccupation:	_____
				Distress:	_____

COMMENTS (include critical items): _____

_____

_____

PATIENT LABEL

D. UCLA – PTSD INDEX FOR DSM-IV

Version Used: ☐ Child *For ages 7 to 12* ☐ Adolescent *For ages 13 to 18*

A – Traumatic Event	Type: _____	DSM-IV Criterion A Met? ☐ Yes ☐ No
B – Reexperiencing	Severity Score: _____	DSM-IV Criterion B Met? ☐ Yes ☐ No
C – Avoidance	Severity Score: _____	DSM-IV Criterion C Met? ☐ Yes ☐ No
D – Increased Arousal	Severity Score: _____	DSM-IV Criterion D Met? ☐ Yes ☐ No

PTSD Overall Severity Score: _____ Severity Degree:

- ☐ Very Severe (>60)
- ☐ Severe (40-59)
- ☐ Moderate (25-39)
- ☐ Mild (12-24)
- ☐ Doubtful (<12)

DSM-IV Full PTSD Diagnosis Likely? ☐ Yes ☐ No

Partial PTSD Diagnosis Likely? ☐ Yes ☐ No

COMMENTS: _____

_____

E. CHILD BEHAVIOR CHECKLIST (CBCL) FOR AGES 6-18

Completed By: _____ Relationship: _____

T-Scores: (*Mean= 50, standard deviation= 10)*

		I. Anxious/Depressed:	_____
Internalizing:	_____	II. Withdrawn/Depressed:	_____
		III. Somatic Complaints:	_____
Externalizing:	_____	IV. Social Problems:	_____
		V. Thought Problems:	_____
		VI. Attention Problems:	_____
Total Score:	_____	VII. Rule-Breaking Behavior:	_____
		VIII. Aggressive Behavior:	_____

COMPETENCY ITEM INFO: _____

_____

CONCERNS/BEST THINGS ABOUT CHILD: _____

_____

_____

OTHER COMMENTS: _____

_____

_____

PATIENT LABEL

F. ADOLESCENT SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY (SASSI-A2)

T-Scores: (*Mean= 50, standard deviation= 10)* *For ages 12 and older*

	T-Score Range	Percentile Rank Exceeded			
Face Valid Alc:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Face Valid Other:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Fam/Friend Risk:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Attitudes:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Symptoms:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Obvious Attributes:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Subtle Attributes:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Defensiveness:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Supp Addiction:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th
Correctional:	_____	☐ 15th	☐ 50th	☐ 85th	☐ 98th

→ Decision Rule: *Check appropriate Probability category and indicate whether VAL & SCS scores meet criteria*

HIGH Probability: ☐ SCS ≤ 15 (Substance Dependence More Probable)
☐ SCS ≥ 16 (Substance Abuse Disorder More Probable)

LOW Probability: ☐ VAL ≥5 or ☐ SCS ≥ 16 (refer for further assessment)

COMMENTS: _____

_____

G. YOUTH SELF REPORT (YSR) FOR AGES 11-18

T-Scores: (*Mean= 50, standard deviation= 10)*

Internalizing: _____

Externalizing: _____

Total Score: _____

I. Anxious/Depressed: _____
II. Withdrawn/Depressed: _____
III. Somatic Complaints: _____
IV. Social Problems: _____
V. Thought Problems: _____
VI. Attention Problems: _____
VII. Rule-Breaking Behavior: _____
VIII. Aggressive Behavior: _____

COMPETENCY ITEM INFO: _____

_____

CONCERNS ABOUT SCHOOL & SELF; BEST THINGS ABOUT SELF: _____

_____

_____

OTHER COMMENTS: _____

_____

_____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 6 TO 18 YEARS

CARETAKER INTERVIEW

WITH: _____

CONDUCTED BY: _____ DATE: _____

A. Please tell me about (child). (Include general information.) _____

B. What information were you given about (child)? (Include child's attributes, family history, substance abuse concerns, drug exposure during pregnancy, etc.)

C. Report of high-risk/ problem behaviors.

- Bed-Wetting
- Nightmares
- Lying
- Aggression/Fighting
- Bullying
- Cruelty (to others, animals)
- Stealing
- Property Damage
- Running Away
- Extreme Risk-Taking
- Substance Use
- Fire-setting
- Psychotic/Bizarre Behavior
- Hallucinations/Delusions
- Truancy
- Self-Injury
- Suicidal Ideation or Gesture
- Sexual Acting Out

D. Report of observed strengths/ positive qualities.

- Self-regulation
- Takes pleasure in activities
- Optimism/Resilience
- Interpersonal skills
- Education/Learns new things
- Talents/Vocation/Interests

PATIENT LABEL

E. Caretaker's view on child's understanding of placement.

- What does the child understand about the reason for placement?
- What have you told or explained to the child? What has the child told you?
- Do you think that the child has a good understanding of why he/she is in foster care?

F. Information regarding child's contact with biological family members.

- Has child asked to see or speak to biological parents? Siblings? Other family members?
- Has child had any contact with parents? Siblings? Other family members?
- How did child react to this contact?

G. Account of child's adjustment to foster home (and foster family's adjustment to child).

- How has the child adjusted to his or her new home?
- How have you (and your family) adjusted?
- Is there anything (support services, therapy, etc.) that could help make the adjustment easier?

H. Overall, how would you rate your feeling about having this child in your home?

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

I. Overall, how would you rate the child's adjustment to your home/to foster care?

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

J. Additional Comments:

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 6 TO 18 YEARS

CHILD INTERVIEW

CONDUCTED BY: _____ DATE: _____

A. Mental status (include activity level, affect, mood, relatedness, orientation x3, appearance, etc).

- What is your name? Age? Birthday (including year)? Address/phone number?
- What grade are you in? Do you like school? What is your favorite subject?
- Who is in your family? Do you have any brothers or sisters?
- Who are these people (i.e., differences between foster parents, biological siblings, etc.)?
- Three wishes?

_____

_____

_____

_____

_____

B. Emotion management

- What kinds of things make you mad? At your old home? At your foster home?
  - Sad? At your old home? At your foster home? Glad? Scared?
- What do you do when you get very mad? Sad? Glad? Scared? How do you make yourself feel better?
- Do you talk to anyone about it? Who? Do they make you feel better?

_____

_____

_____

_____

_____

C. Child's report of high-risk or problem behaviors.

Did you/ do you ever:

- Lie to someone?
- Have nightmares?
- Hurt animals?
- Play with matches? Set fires?
- Run away from home?
- Think about hurting yourself? (Or, hurt yourself?)
- Think about hurting someone else? (Or, hurt someone else?)
- Get into fights? With who?
- Take something from someone that wasn't yours?
- Use drugs or alcohol? What kinds? How much? How often?
- If you did something wrong at your old house, what happened?

_____

_____

_____

_____

_____

PATIENT LABEL

D. Child's understanding of foster care system and reason for placement.

- How come you don't live with your biological parents/family?
- Did something happen before you moved to your new house? What happened?
- Why do you think you weren't allowed to stay in your old house? Who decided that?
- Who told you that you weren't allowed to stay there anymore? What else did they tell you?
- Who do you think is responsible for you living in a foster home?

- What do you think DYFS does? What is it? Who are they?
- Why do you think kids are put into foster care?
- Part of DYFS' job is to protect kids, and now that you aren't in your old house, do you feel safer?
- How do you think it's safer? Do you feel protected? Did you ever feel unsafe in your old house?

E. Child's sense of safety (in both past and current placements).

- What is your new house like?
- Do you always have enough to eat?
- Do you have enough clean clothes now? If it's cold out, do you have a warm jacket to wear?
- Does your foster family ever leave you alone for a long time?
- Where do you sleep? Do you share a room with someone? Do you have your own bed?

- Did anyone at your old house ever: Yell at each other?
    - Hurt each other? (Who? Why?)
    - Drink alcohol or use drugs?
    - Touch you in a way that made you feel uncomfortable?
    - Do anything else that you thought was bad?

PATIENT LABEL

- Have you seen or talked to your Mom/Dad/siblings/other relatives?
  - Do you like seeing them?
- What do you miss most about your old house?

- Does anyone at your foster home ever: Yell at each other?
  - Hurt each other? (Who? Why?)
  - Drink alcohol or use drugs?
  - Touch you in a way that made you feel uncomfortable?
  - Do anything else that you think is bad?

- How do you feel about living in your foster home?
- Do you like your foster family? What about them do you like?
- How are they different from your other family?

F. Child's rating of his/her adjustment to foster placement:

Bad/negative ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Good/positive

G. Information from Foster Care Perceptions Scale.

H. Additional comments:

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MENTAL HEALTH REPORT
AGES 6 TO 18 YEARS

MENTAL HEALTH SUMMARY AND RECOMMENDATIONS

TESTING SUMMARY: _____

SUMMARY: _____

RECOMMENDATIONS: _____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MEDICAL REPORT

MEDICAL HISTORY – RECORDS REVIEW

A. MATERIALS REVIEWED BY CHEC TEAM TO SUPPORT THE OPINIONS & RECOMMENDATIONS IN THIS REPORT

- ☐ Birth Records
- ☐ Immunization Records
- ☐ Hospital Records
- ☐ DYFS History, 9-7 Referrals
- ☐ Imaging Studies
- ☐ Specialty Consultations
- ☐ Growth Charts
- ☐ ER Visits
- ☐ Primary Care Provider Records
- ☐ School Information
- ☐ Other: _____
- ☐ Other: _____

***NOTE*: please indicate if source of information is source other than records review**

B. BIRTH HISTORY ☐ **No information available**

- ☐ Prenatal Care for Mother
  - ☐ Prenatal Hep B + –
  - ☐ Prenatal HIV + –
  - ☐ Prenatal RPR + –
  - ☐ Prenatal Other: _____
- ☐ Prenatal Complications (*specify below*)
- ☐ Neonatal Complications (*specify below*)
- ☐ Neonatal Immunizations (*specify below*)
- ☐ Birth Hospital _____
- ☐ Delivery Complications (*specify below*)
- ☐ Vaginal ☐ C Section
- ☐ Gestational Age _____
- ☐ Birth Wt._____ Ht._____ H.C._____

COMMENTS: _____

C. NEONATAL TESTING ☐ **No information available**

Newborn Screen	HIV (date)	Drug Screening	OAE/Hearing Screen	Other
☐ abnormal	☐ positive	☐ positive	☐ failed	
☐ normal	☐ negative	☐ negative	☐ passed	
☐ unk	☐ unk ☐ not done	☐ unk ☐ not done	☐ unk ☐ not done	

COMMENTS: _____

D. MEDICAL HISTORY ☐ **No information available**

Immunizations	Dental Care	Allergies
☐ up to date	☐ yes *(specify)* _____	☐ yes *(specify)* _____
☐ delayed	☐ no _____	☐ no _____
☐ records not available	☐ unk	☐ unk

Hospitalizations/Surgeries	ER Visits	Significant Injuries
☐ yes *(list)* _____	☐ yes *(specify)* _____	☐ yes *(specify)* _____
☐ no _____	☐ no _____	☐ no _____
☐ unk	☐ unk	☐ unk

Behavior & Development	Growth & Nutrition	Special Services
☐ normal	☐ normal	☐ PT ☐ OT
☐ abnormal	☐ abnormal	☐ Speech
☐ unk	☐ unk	☐ Mental Health
		☐ Other: _____

COMMENTS: _____

RN OR MD SIGNATURE _____

MEDICAL REPORT

PATIENT LABEL

D. MEDICAL HISTORY – CONTINUED

Diagnoses ☐ None

Medications ☐ None

Specialists ☐ None

COMMENTS:

E. RESULTS OF PREVIOUS SCREENINGS (include dates, results)

Lead _____ Hemoglobin/Hematocrit _____

PPD _____ Hearing _____

Sickle Cell _____ Vision _____

HIV _____ Other _____

COMMENTS:

F. PERTINENT FAMILY HISTORY (PER RECORDS REVIEW): FAMILY MEDICAL HX FORM ATTACHED? ☐ Yes ☐ No

RN OR MD SIGNATURE _____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MEDICAL REPORT

MEDICAL HISTORY – ACTIVE INTERVIEW

Date of Visit: _____ Child accompanied to visit by: _____

Information provided by: ☐ Patient ☐ Foster Parent ☐ DYFS Worker ☐ Other: _____

A. MEDICAL CONCERNS

_____

_____

_____

B. REVIEW OF SYSTEMS

Skin: _____

HEENT: _____

Hematologic: _____

Cardiac: _____

Respiratory: _____

GI: _____

GU: _____

GYN/Menstrual: _____

Skeletal/Musc: _____

Nutrition: _____

Development: _____

Neuro/Psych: _____

C. PSYCHOSOCIAL ISSUES

Home: _____

Education: _____

Activities/Peers: _____

Drugs: _____

Alcohol: _____

Smoking: _____

Sexuality: _____

Body Image: _____

Sleep: _____

Violence: _____

Mood: _____

D. PERTINENT FAMILY HISTORY

_____

_____

COMMENTS: _____

_____

_____

_____

RN OR MD SIGNATURE _____

MEDICAL REPORT

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MEDICAL REPORT

PHYSICAL EXAMINATION

T _____ Wt. _____ kg (_____)% Hearing ☐ pass ☐ fail ☐ unable to complete

HR _____ Ht. _____ cm (_____)% Vision ☐ pass ☐ fail ☐ unable to complete

RR _____ HC _____ cm (_____)% Pain ☐ no ☐ yes *(specify)* _____

SaO2 _____ BP _____ Allergies ☐ none ☐ yes *(list)* _____

_____

GENERAL _____

Check box if Normal; specify if Abnormal

Normal		*Normal*	
☐ Head	_____	☐ Heart	_____
☐ Eyes	_____	☐ Abdomen	_____
☐ Ears	R _____	☐ Extremities	_____
	L _____	☐ Back	_____
☐ Nose	_____	☐ Genitalia	_____
☐ Mouth/Throat	_____	☐ Neuro	_____
☐ Neck	_____	☐ Skin	_____
☐ Nodes	_____		
☐ Chest/Lungs	_____	☐ Other	_____

COMMENTS: _____

_____

_____

HEALTH MAINTENANCE/EPSDT

Dental Care	Vitamins & Fluoride	Growth/Nutrition	Development	Behavior
☐ age appropriate	☐ _____	☐ age appropriate	☐ age appropriate	☐ age appropriate
☐ refer	☐ N/A	☐ at risk	☐ at risk	☐ at risk
		☐ WIC: Y N		

IMMUNIZATIONS ☐ Up-to-date prior to CHEC visit ☐ Additional immunizations still required (see Plan of Care)

☐ **Given during CHEC visit:**

☐ DTaP	☐ Hepatitis B	☐ IPV	☐ Influenza	☐ Other _____
☐ Pediarix	☐ Comvax	☐ MMR	☐ Meningococcal	☐ Other _____
☐ Prevnar	☐ Hib	☐ Varivax	☐ Td	

SCREENING TESTS ☐ Up-to-date prior to CHEC visit ☐ Additional screenings still required (see Plan of Care)

☐ **Performed during CHEC visit:**

☐ CBC	☐ EP	☐ Urine for STD Screen	☐ Hepatitis B	☐ Cholesterol
☐ Lead	☐ UA (dipstick)	☐ Urine Toxicology	☐ Hepatitis C	☐ HIV Screen
☐ PPD- *date to be read:* _____		☐ Other _____		*(consent must be obtained)*

LAB/TESTING RESULTS: _____

_____

_____

_____

RN OR MD SIGNATURE _____

PATIENT LABEL

COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN – MEDICAL REPORT

MEDICAL ASSESSMENT AND PLAN

RN OR MD SIGNATURE _____

NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: _____ **Date of Birth:** _____
NJS: Case# _____ **Person ID#** _____
Casework/supv/contact info _____

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	
			Behavior
☐	☐	☐	1. Does this child exhibit unusual or uncontrollable behavior? **0 – 18 mos**: Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness **18 – 36 mos**: Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger **3 – 5 yrs**: Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)
☐	☐	☐	2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn? **0 – 18 mos**: Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems. **18 – 36 mos**: Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues. **3 – 5 yrs**: Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).
☐	☐	☐	3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property? *Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.*
			Placement, Childcare, Education Status
☐	☐	☐	4. Does this child exhibit behaviors that may **not** allow him/her to remain in his/her current living, preschool and/or childcare situation? *The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.*
			History
☐	☐	☐	5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days? *Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas ,rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.*

Please continue to page 2

If you checked any of the above boxes "YES", child should be referred for assessment. For the young child, a next step will usually include a consult with the child's pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.

If applicable, identify the agency and provider to which the child has been referred:

_____

COMMENTS/ADDITIONAL INFORMATION: _____

_____

_____

_____

NEW JERSEY MENTAL HEALTH SCREENING TOOL (6 YEARS TO ADULT)

Child's Name: _____ **Date of Birth:** _____
NJS: Case# _____ **Person ID#** _____
Casework/supv/contact info _____

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please indicate the issues under the COMMENTS section on the reverse side of the form.

YES	NO	Unknown	Part 1 - IDENTIFIED RISK
☐	☐	☐	1. Has this child been a danger to him/herself or to others in the last 90 days? *Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.*
☐	☐	☐	2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy? *Persistent chaotic, impulsive or disruptive behaviors; daily verbal outburst; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other disciplines, etc.*
☐	☐	☐	3. Has the child exhibited bizarre or unusual behaviors in the last 90 days? *History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (head banging) or vocalizations (e.g. echolalia); smears feces, etc.*
☐	☐	☐	4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill? *Either needs immediate evaluation of medication or needs a new prescription.*
☐	☐	☐	5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication? *Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.*
☐	☐	☐	6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days? *Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.*

If you checked any of the above boxes YES, this indicates that the need for Mental Health assessment and/or assistance is urgent.

If all the above are either NO or UNKNOWN, please continue on reverse side.

COMMENTS/ADDITIONAL INFORMATION: _____

_____

YES	NO	Unknown	Part 2 - RISK ASSESSMENT
☐	☐	☐	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____
☐	☐	☐	2. Does the child have problems with social adjustment? *Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confirmed due to serious law violations; does not seem to feel guilt after misbehavior, etc.*
☐	☐	☐	3. Does this child have problems making and maintaining healthy relationships? *Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.*
☐	☐	☐	4. Does this child have problems with personal care? *Eats or drinks substances that are not food; regularly enuretic during waking hourse (subject to age of child); extremely poor personal hygiene.*
☐	☐	☐	5. Does this child have significant functional impairment? *No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.*
☐	☐	☐	6. Does this child have significant problems managing his/her feelings? *Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive, etc.*
☐	☐	☐	7. Is this child known to abuse alcohol and/or drugs? *Child regularly uses alcohol or drugs.*

If you checked any of the above boxes YES, this indicates child should be referred for a mental health assessment.

Please forward the form to:

(Could be preprinted to have the address of local Mental Health agency.)

COMMENTS/ADDITIONAL INFORMATION: _____

_____

Mental Health Follow Up Response

Name: _____ Date: _____

☐ MH Assessment complete; no follow up MH service required.

☐ MH Assessment complete; MH follow up required.

☐ Other: _____

BRIGHT FUTURES TOOL FOR PROFESSIONALS

INSTRUCTIONS FOR USE

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

INSTRUCTIONS FOR SCORING

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

REFERENCES

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Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			

NJS Person ID#:

STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD PROTECTION AND PERMANENCY
Health Passport and Placement Assessment

A. IDENTIFYING INFORMATION

Child's Name (First/Middle Initial/Last)
Sex: Male ☐ Female ☐ Date of Birth:
Case ID#: Person ID#:

Type of current placement:
Placement episode start date: Date of current placement:
County of placement:

Medicaid#:
Medicaid HMO:

CHU Nurse:
CP&P Worker:
CP&P Supervisor:
Local Office:
Health Information obtained from: Medical Records ☐ Family Historian ☐ NJIIS ☐
Health Focus ☐ Other
PPA Attached: Yes ☐ No ☐

B. SIGNIFICANT HEALTH INFORMATION

1. Birth History: Name of birth hospital:
Location:
Child's birth weight: Child's birth height:
Child's head circumference:
Full Term: Yes ☐ No ☐ Unknown ☐
Gestational Age:
Delivery:
Newborn Hearing Screen: Pass ☐ Fail ☐ Unknown ☐
Prenatal Care: Yes ☐ No ☐ Unknown ☐
Drug/Alcohol exposed: Yes ☐ No ☐ Unknown ☐ If yes, please describe and include type of drug/alcohol:
Other significant birth history:

2. Health History
Hospitalization? Yes ☐ No ☐ Unknown ☐ If yes, please describe reason, treatment, procedure, date and hospitalization location:
History of injuries / illness/ significant childhood diseases? Yes ☐ No ☐ Unknown ☐
If yes, please describe:

NJS Person ID#:

3. Family History

Is there a family history of medical problems? Yes☐ No ☐ Unknown☐
If yes, please describe:

4. Current Health

Current Weight: Height: Head Circumference: BMI:
Current health problems / illnesses / conditions:

Does the child have any allergies? Yes☐ No ☐ Unknown☐
If yes, please describe:
Epinephrine Auto-Injector (EpiPen) Required: Yes ☐ No ☐

Last EPSDT Visit: Date:

Immunization review Date:

Last Dental Exam (3 years and older): Date:

Developmental History: On Target ☐ Delayed ☐
(Please list and date latest milestones and tasks attained):

Is the child receiving therapy? Yes ☐ No ☐ (check those that apply):
Physical Therapy☐ Occupational Therapy ☐ Speech Therapy ☐
Other☐
Frequency/schedule of therapy:

Is the child receiving services from EIP (Early Intervention Program)? Yes☐ No☐
Name of EIP Provider:

Is the child receiving SCHS (Special Child Health Services)? Yes☐ No☐

Does the child have an education classification?
Yes ☐ No ☐ Unknown ☐
If yes, what is classification?

Vision Problems: Yes ☐ No☐ Unknown ☐
If yes, please describe:
Does the child wear glasses? Yes ☐ No☐ Unknown ☐
Does the child wear contact lenses?
Yes ☐ No ☐ Unknown ☐

Hearing Problems: Yes ☐ No☐ Unknown ☐
If yes, please describe:

Does the child have any special transportation needs (i.e. requires transportation in an

NJS Person ID#:
ambulance or van with a wheelchair lift)? Yes ☐ No ☐
If yes, what are those needs?

5. Current Health Providers / Medications:
Name & Specialty Address Phone

Name of medication:
Are the information sheets on the medication side effects included? Yes☐ No☐
Is this prescribed as a psychotropic medication? Yes ☐ No ☐
If yes, is consent on file? Yes ☐ No ☐
If child is on psychotropic medication, is there a treatment plan? Yes ☐ No ☐

6. Have the following tests been completed?

TESTS (If Known)	Date	Results
Newborn screening		
Sickle Cell		
Hepatitis B		
Hepatitis C		
HIV		
PPD		
Lead Level		
Hemoglobin		
Urinalysis		
Vision Screen		
Hearing Screen		
Blood Pressure Screening		
Cholesterol Screen		
STD Screen		
Pelvic Exam with PAP for all sexually active females		
Other		
Other		
Other		

7. Summary / Assessment / Specific Care Needs / Transportation

8. Acuity Level

9. Care Giver Requirements

10. Health Plan

11. Signature

NJS Person ID#:
Name of CHU Nurse completing form:
Date:
Signature:
Contact Number:

NJS Person ID#:

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
Division of Child Protection and Permanency
PEDIATRIC NURSING REPORT

Child's Name (First/Middle Initial/Last)
Sex: ☐ Male ☐ Female Date of Birth:
Case ID#: Person ID#:

Medicaid#:
Medicaid HMO:

Date of Visit:
Resource Provider:
Address: **Telephone #:**

Current Health Providers / Medications:
Name & Specialty Address Phone

Name of medication:
Name and title of person prescribing medicine:

Current Health:
Current Weight: Height: Head Circumference: BMI:
Current health problems/illnesses/conditions:
Does the child have any allergies? Yes ☐ No ☐ Unknown ☐ If yes please describe:
Epinephrine Auto-injector (Epi-Pen) required: Yes ☐ No ☐

Developmental History: On Target ☐ Delayed ☐
(Please list and date latest milestones and tasks attained):

Is the child receiving therapy? Yes ☐ No ☐ (check those that apply):
Physical Therapy☐ Occupational Therapy ☐ Speech Therapy ☐
Other☐
Frequency/schedule of therapy:

Is the child receiving services from EIP (Early Intervention Program)? Yes☐ No☐
Name of EIP Provider:

Is the child receiving SCHS (Special Child Health Services)? Yes☐ No☐

Does the child have an education classification?
Yes ☐ No ☐ Unknown ☐
If yes, what is classification?

NJS Person ID#:
Vision Problems: Yes ☐ No☐ Unknown ☐
If yes, please describe:
Does the child wear glasses? Yes ☐ No☐ Unknown ☐
Does the child wear contact lenses?
Yes ☐ No ☐ Unknown ☐

Hearing Problems: Yes ☐ No☐ Unknown ☐
If yes, please describe:

Have the following tests been completed?

TESTS (If Known)	Date	Results
Newborn screening		
Sickle Cell		
Hepatitis B		
Hepatitis C		
HIV		
PPD		
Lead Level		
Hemoglobin		
Urinalysis		
Vision Screen		
Hearing Screen		
Blood Pressure Screening		
Cholesterol Screen		
STD Screen		
Pelvic Exam with PAP for all sexually active females		
Other		
Other		
Other		

Summary / Assessment / Specific Care Needs / Transportation:

Acuity Level:

Anticipatory Guidance
☐ Feeding / Colic / No Bottle in bed / Honey Restrictions
☐ General Safety ☐ Bath Safety ☐ Shaken Baby Syndrome☐ Fever Protocols
☐ Crib Safety / Mattress Lowered ☐ Bedtime Rituals / Sleep Habits
☐ Child Care Issues☐ Stranger Anxiety☐ Parenting Issues
☐ Appropriate Car, Booster Seat or Seat Belts☐ Lead Poison Prevention
☐ Passive Smoking / Smoking
☐ General Development ☐ Language Stimulation / Development

NJS Person ID#:
☐ Teething ☐ Oral Health Care ☐ Weaning to cup ☐ Toilet Training
☐ Nutrition/ Weight Control ☐ Regular Physical Activity ☐ Helmets
☐ Discipline Limits ☐ TV Habits / Limits ☐ Siblings / Friendships / Peer Relationships
☐ School Readiness /Issue ☐ After School Supervision
☐ Matches, Poisons, Guns, Firearm Safety ☐ Violence Prevention ☐ Drugs / Alcohol
☐ Menarche ☐ Self Exam ☐ Acne ☐ Sexual Behavior ☐ STD / HIV / AIDS
☐ Body Image ☐ Suicide / Depression ☐ Plans for Work / Work ☐ Driving
☐ Significant Others / Social Relationship ☐ Plans for Secondary Education

Health Plan:

Signature:

Name of CHU Nurse completing form:
Date:
Signature:
Contact Number:

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
Child Protection and Permanency

CONTACT SHEET

Case ID:	Case Name:	
Date Occurred:	Date Entered:	Created By:
Category:	Type of Activity:	
Method:	Place:	Result:
Site/Office: Primary Worker : Supervisor :		
Narrative:		
Contact With:		
Other Contacts:		
Investigation Contacts:		

NOTE: The Worker electronically approves each entry in NJ SPIRIT. The Supervisor reviews entries every 30 days or more frequently if the case warrants. The Supervisor's review and approval of each entry is electronically recorded in NJ SPIRIT.

Chapter 3 Well-Care for Children in Placement

Introduction

All children in placement are entitled to adequate well-child care and timely immunizations.

The Early and Periodic Screening, Diagnosis, and Treatment (**EPSDT**) Program is a comprehensive and preventive health program for children up to age 21. It is a Medicaid requirement in every state, and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. As the acronym suggests, there is early identification and routine screening for physical as well as mental health needs of a child during EPSDT evaluations.

Well-Child Visits

EPSDT evaluations are done at every Well-Child Visit, in the office setting, for children covered by Medicaid (now also known as NJ Family Care). Following the initial newborn visit in the first week of life, EPSDT evaluations should be scheduled at 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years and annually thereafter until age 21. These well-child examinations include appropriate immunizations and screenings. (see *Recommendations for Preventive Pediatric Healthcare, aka: Periodicity Chart*)

During these visits, a complete history is taken, and a head-to-toe physical examination is performed. During the visit, parents/caregivers -- and later on the patients themselves -- are encouraged to ask questions and participate in decisions about the child's medical care, and anticipatory guidance about growth and development is provided. Development is assessed, growth parameters are plotted on appropriate growth charts (see *Pediatric Growth Charts* for both boys and girls), and hearing and vision screenings are done. In addition, the physician assesses the child's dental health, screens for the risk of lead exposure and other environmental risks such as secondhand cigarette smoke, and provides age-appropriate safety counseling.

The Well-Child visit is a time to gather a wealth of information in all areas of the child's life. EPSDT evaluations allow the physician, the parent/caregiver, and the child to identify any barriers that might interfere with the child's attaining optimal development and growth (e.g., barriers due to underlying chronic disease or social challenges). During these visits, the physician may gather more clinical information with diagnostic testing, including laboratory work or imaging

studies. Subsequently, a diagnosis can be made in a timely fashion and appropriate treatment or referral to a specialist can be initiated. Follow-up care and management of acute and chronic diagnoses become part of each EPSDT visit.

The periodicity -- or frequency -- of EPSDT evaluations varies with a child's age. In the child's first year of life, there are at least six expected Well-Child EPSDT assessments; after the age of two, there is one visit per year (see *Recommendations for Preventive Pediatric Healthcare, aka: Periodicity Chart*).

EPSDT or Well-Child visits should be made when the child is not sick, so that the health care provider can do a complete and thorough examination.

Child Growth and Growth Charts

A child's height, weight, and head circumference can be influenced by a variety of factors, including genetics, gender, nutrition, physical activity, environment, health problems, and pre-natal factors. Doctors rely upon Growth Charts to help determine whether a child's size and growth are "normal" (how that child's growth compares with other children of the same age and gender), and to track development, and detect potential health problems.

Growth Charts should be used at a child's Well-Child or EPSDT visit, with length, weight, and head circumference measured and plotted on the Growth Charts for children 0 to 24 months old, and with stature, weight, and BMI measured and plotted on the Growth Charts for children 2 to 20 years old. Blank Growth Charts are provided in this manual, but can also be downloaded from the Center for Disease Control at http://www.cdc.gov/growthcharts/clinical_charts.htm.

Measurement of head circumference is an important part of routine well child care for children under the age of three. Head circumference is measured in centimeters and compared with previous measurements and normal ranges that are based on gender and age (weeks, months). A deviation from the expected normal head growth may alert the doctor to a possible problem. For example, a head that is larger than normal or whose size is increasing faster than normal may be a sign of increased intracranial pressure, which can be caused by any number or problems including water on the brain (hydrocephalus). An exceptionally small head size (called microcephaly) or very slow growth rate may be a sign that the brain is not developing properly.

In general, the doctor is looking less at the actual numbers and more at the child's pattern of growth. For example, if a baby was born at the 10th percentile and continued along at that curve, remaining on the small side, this would be no

cause for concern. However, if a child was born at the 50th percentile and at their 4 month Well-Child visit dropped down to the 5th in one of the criteria (such as head growth), this would be cause for concern. While there are many variables involved, if a child has significantly increased or decreased in their percentile for weight, height, or head circumference, this is cause for an evaluation.

Immunizations

Perhaps one of the most important things that can be done for children and youth in placement is to assure that their immunizations are up to date, and that the parents, caregivers, and later the youths themselves, are in possession of their immunization record at times of transition. These critical transition times include:

- Transition to a new care site;
- Transition in placement;
- At the time of reunification, adoption, or other permanency arrangement;
- When the youth ages out of the system;
- Other transitional life events that demand such records (e.g., starting a new school, entering college, or being enrolled in an athletic program or summer camp).

Significantly, it is also a challenge and goal not to over-immunize children and youth in placement.

Addressing the challenge of obtaining and reconciling Immunization Records

There are a number of challenges in obtaining and reconciling immunization records:

- Many children and youth enter out-of-home care with lapses in their immunizations.
- At the same time, children or youth who have been in multiple placements over the years may face the risk of being over-immunized if there has been a lack of coordination in gathering their immunization records or reconciling all of their vaccines into the state vaccine registry system.
- Vaccine records for children and youth in placement may have to be pieced together from a variety of sources, including: records from biological parents, discussions with caregivers regarding where they have taken children for immunizations, records from various providers or clinics, and reviews of vaccine records from daycare centers and schools.

Ideally, when a child receives any state-funded vaccine, a record of that vaccine is entered into the state VFC registry (NJIIS) by the provider that administered it. However, in New Jersey, children who have received doses of vaccines when covered by private insurance, and children who have been immunized out of state or in foreign countries, may not have complete vaccine records in NJIIS (unless their provider has taken the time to reconcile their record in NJIIS). Thus, just querying the state registry for a youth's immunization record may provide an incomplete record and may lead to repeat vaccines and/or over-immunization.

For school-age children, the best source of a vaccine record may be from the child's most recent school.

Sites providing Comprehensive Medical Exams (CMEs) can reconcile past vaccines and vaccines given at the time of the CME visit in NJIIS. However, CME sites can only enter the records they have been provided with at the time of the CME exam and, sometimes, children are sent to CME evaluations with no vaccine records. The Child Health Units (CHUs) attempt to send vaccine records prior to CME evaluations.

CASA volunteers can be helpful in assisting DCP&P caseworkers and/or CHU nurses in locating all vaccine records, even after CME evaluations have been done. Once they have received as complete a vaccination record as possible, a child or youth's primary care provider office or clinic should be able to input past vaccines into NJIIS. The goal is to provide every youth in placement with an up-to-date, reconciled vaccine record as they transition through placements, and certainly by the time they leave state custody.

Immunization Schedules

At the beginning of each year, updated schedules for administering Food and Drug Administration (FDA) approved vaccines are published. These schedules are developed by the Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP), by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). Most often, three schedules are provided to offer advice in the administration of immunizations for children ages 0 – 6 years, 7 – 18 years, and for young adults ages 18 and up. While these *Immunization Schedules* are contained in this manual, the most up to date schedules can be found at http://www.cdc.gov/vaccines/acip/index.html (for the CDC website) or https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunization/Pages/Immunization-Schedule.aspx (for the AAP website). Note: Changes are made in vaccine administration protocol each year

as well as when new vaccines are developed or when vaccines are taken off the market.

Any child entering public school or preschool in New Jersey will be required to comply with the New Jersey Preschool and Public School Immunization Requirements (see *NJ Preschool Immunization Requirements* and *NJ Public School Immunization Requirements*). However, under certain circumstances, parents and/or caregivers can request exemption from immunization (see *Religious Exemption from Immunization Requirements*).

Immunizations and Adverse Events

Clinicians and caregivers should report any significant adverse events that may follow an immunization to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be obtained at http://www.vaers.hhs.gov, or by calling 1(800)822-7967. This information should be given to the caregiver at the visit where immunizations are administered.

Points of Advocacy for CASA

- CASAs should ensure the child gets age-appropriate well-care, immunizations, and needed follow-up. When appropriate, CASA should assist the caregiver in learning how to review EPSDT and immunization information.
- CASAs are not responsible for, nor should they be, assessing their assigned child's development or well-being, but should work in collaboration with the child's DCP&P caseworker, CHU nurse, primary care physician, and caregivers to ensure that any and all medical and developmental needs are being met.
- CASAs can play an important role in ensuring that children have their well-child and EPSDT visits and that immunizations are up to date. CASAs can help locate vaccine and medical records and ensure that those records are kept up to date.
- CASAs can help to ensure that vaccine (and all medical) records follow the child through out-of-home placement to permanency or emancipation. CASAs should make sure caregivers receive the necessary records and know how to access what is needed for school, etc.
- If a child is below 5th percentile or above the 95th percentile in weight, length/stature, head circumference, or body mass index, or if the child's percentiles in any area significantly increase or decrease, the CASA should consider this a red flag and request further evaluation.
- CASAs should advise caregivers to report immediately to the child's healthcare provider any adverse reactions to vaccinations. The

healthcare provider should then access the Vaccine Adverse Event Reporting System to report the reaction.

Manual Documents:

- Recommendations for Preventive Pediatric Healthcare, aka: Periodicity Chart
- Pediatric Growth Charts for boys and girls 0-24 months
- Pediatric Growth Charts for boys and girls 2-20 years
- Immunization Cheat Sheet – Up to Age 1
- Immunization Schedule 0-6 years
- Immunization Schedule 7-18 years
- Immunization Schedule – Combined 0-18 years
- Immunization Schedule 18 years and older
- NJ Preschool Immunization Requirements
- NJ Public School Immunization Requirements
- Religious Exemption from Immunization Requirements

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[9]								●			●		●																			
Autism Screening[10]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●				●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																
Newborn Blood Screening[15]		◄———	●	———►																												
Critical Congenital Heart Defect Screening[16]		●																														
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★															
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	◄———	●	———►	★	★	★	★	★	★	◄———	●	———►	
STI/HIV Screening[23]																						★	★	★	★	★	◄———	●	———►	★	★	★
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
Fluoride Varnish[26]							◄———	●	———►																							
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/early/2009/11/24/peds.2009-2571.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.creatingdoctors.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.integration.samhsa.gov/clinical-practice/screening-tools.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreenpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/127/5/905.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://redbook.aappublications.org/site/resources/immschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2016 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/137/1/e20153986.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030112.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/126/5/1021.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/gynecacy.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/620), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/620).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄——● ——► = range during which a service may be provided

Summary of changes made to the
Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening**- The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, "A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).

Changes made May 2015

- **Oral Health**- A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626) and 2014 policy statement, "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Changes made March 2014

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment**- Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**- Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening**- An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**- A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**- A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled "STI Screening."
- **Cervical dysplasia**- Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease**- Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

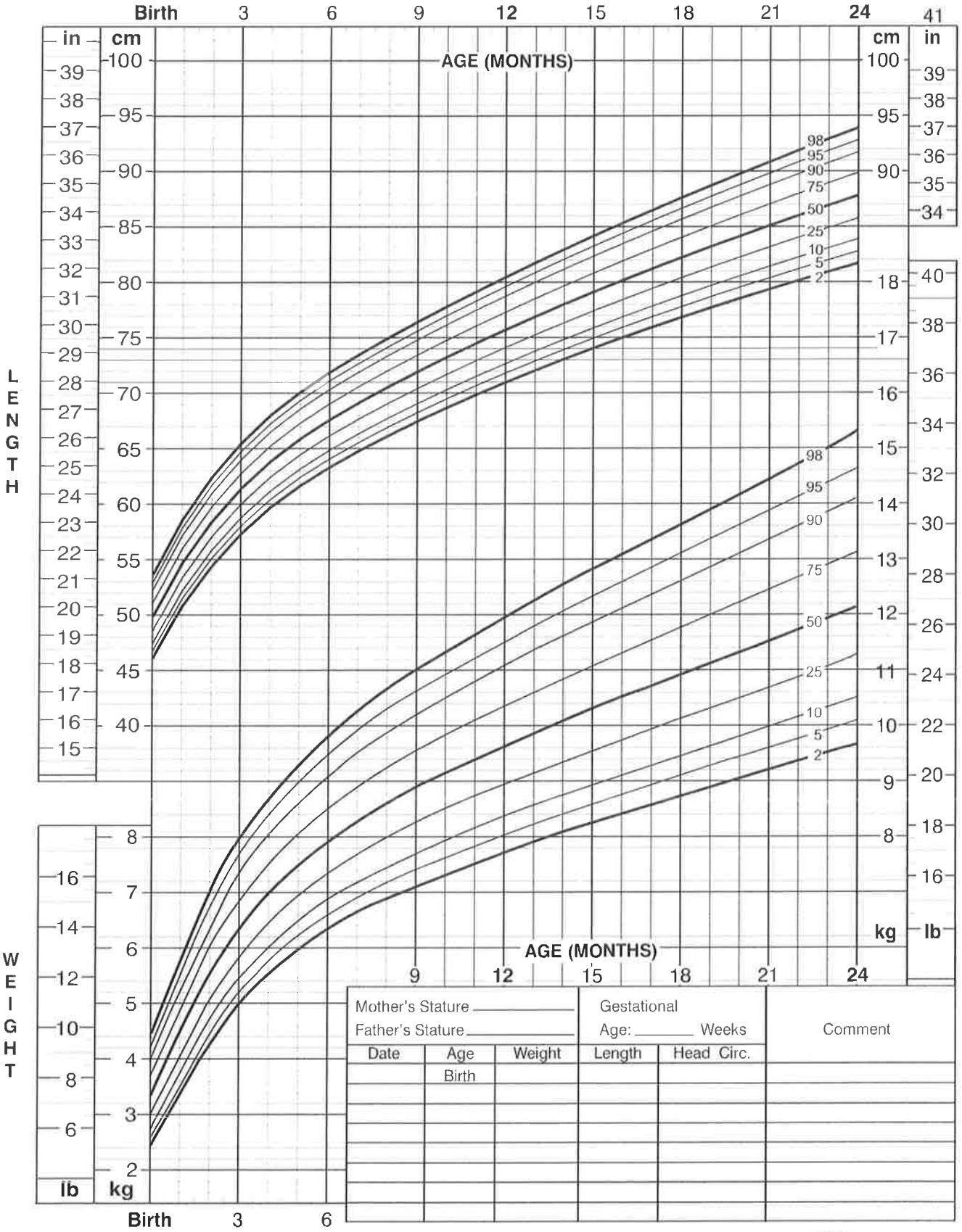
See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.

MD3-2

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

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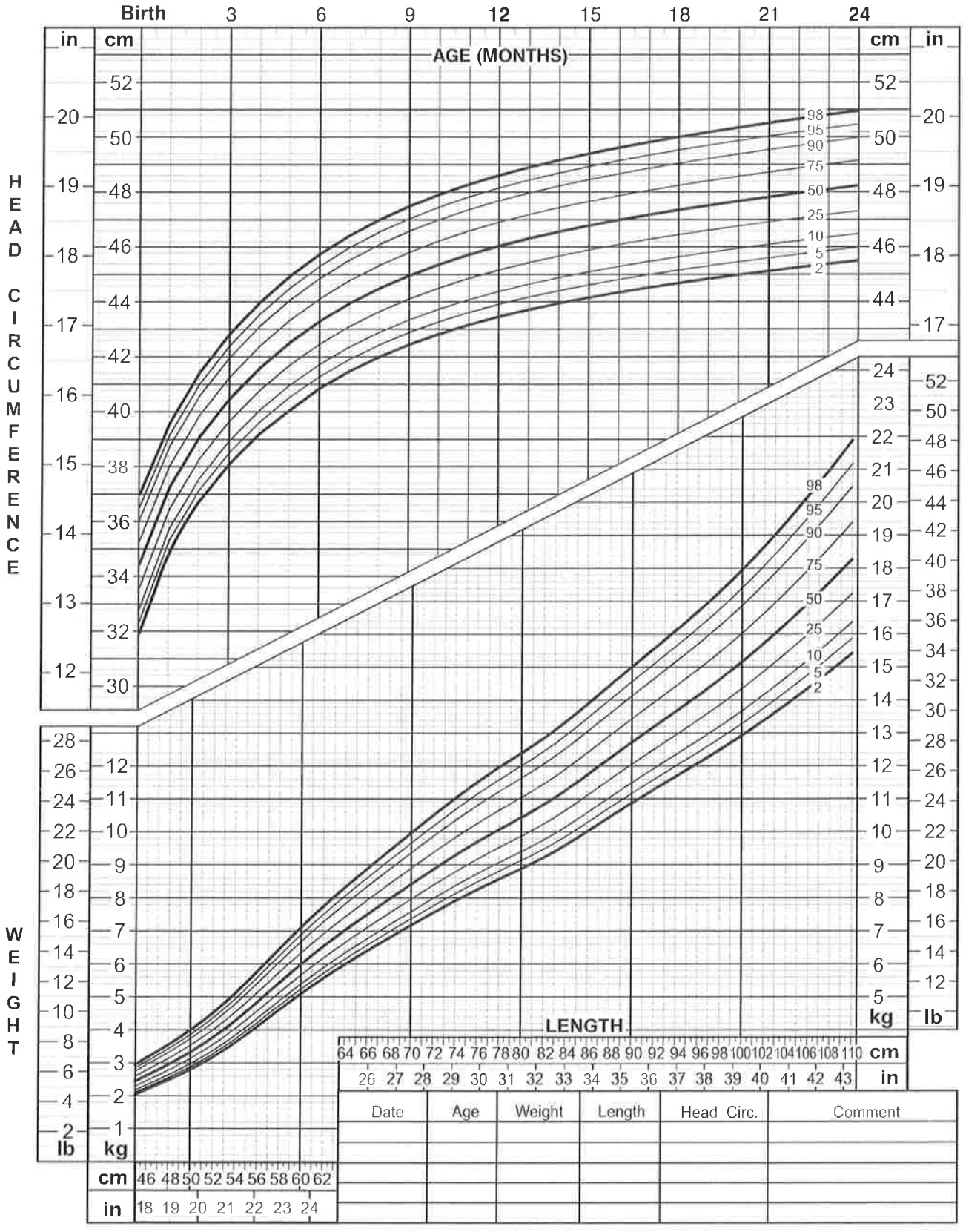
Birth to 24 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____

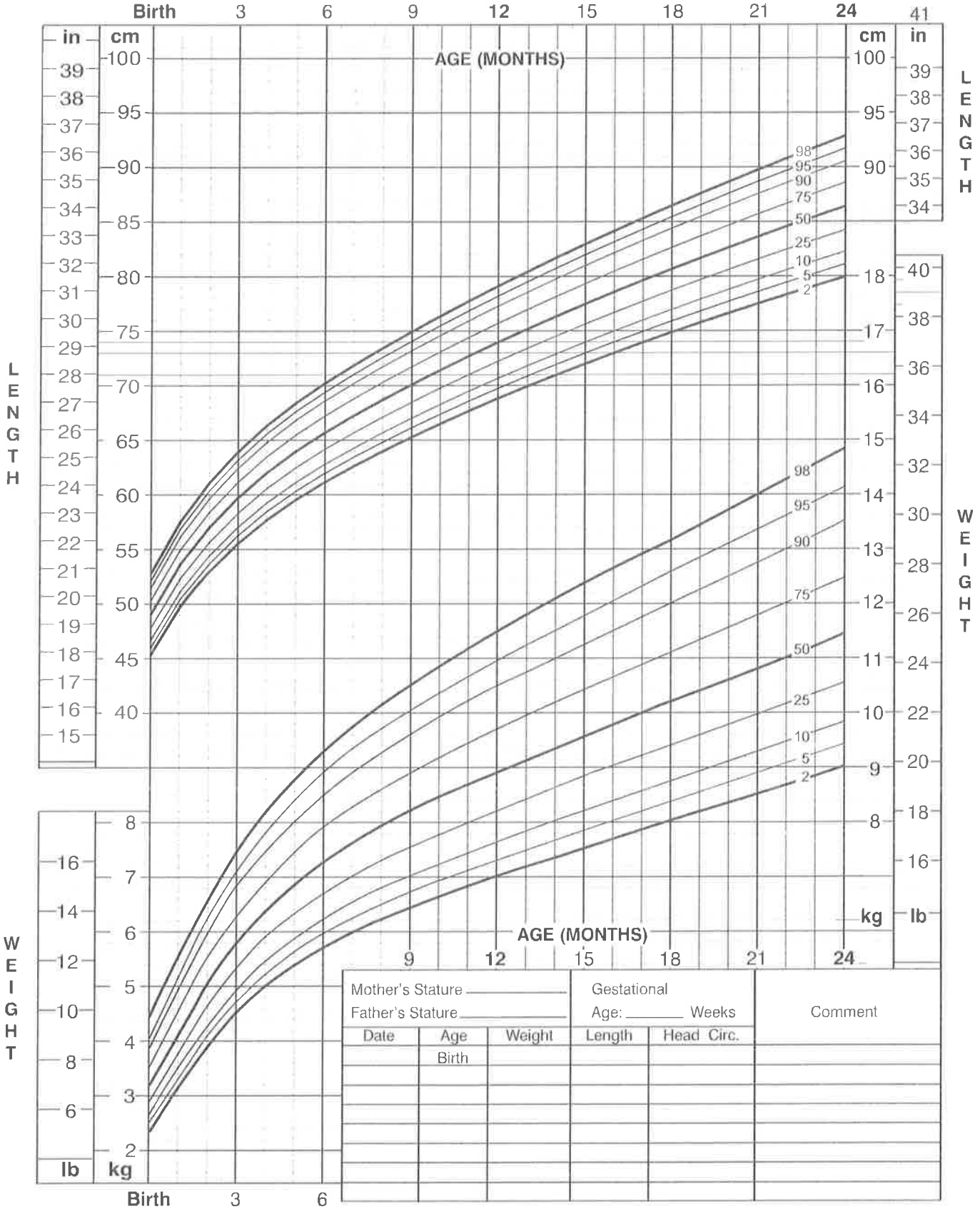


Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



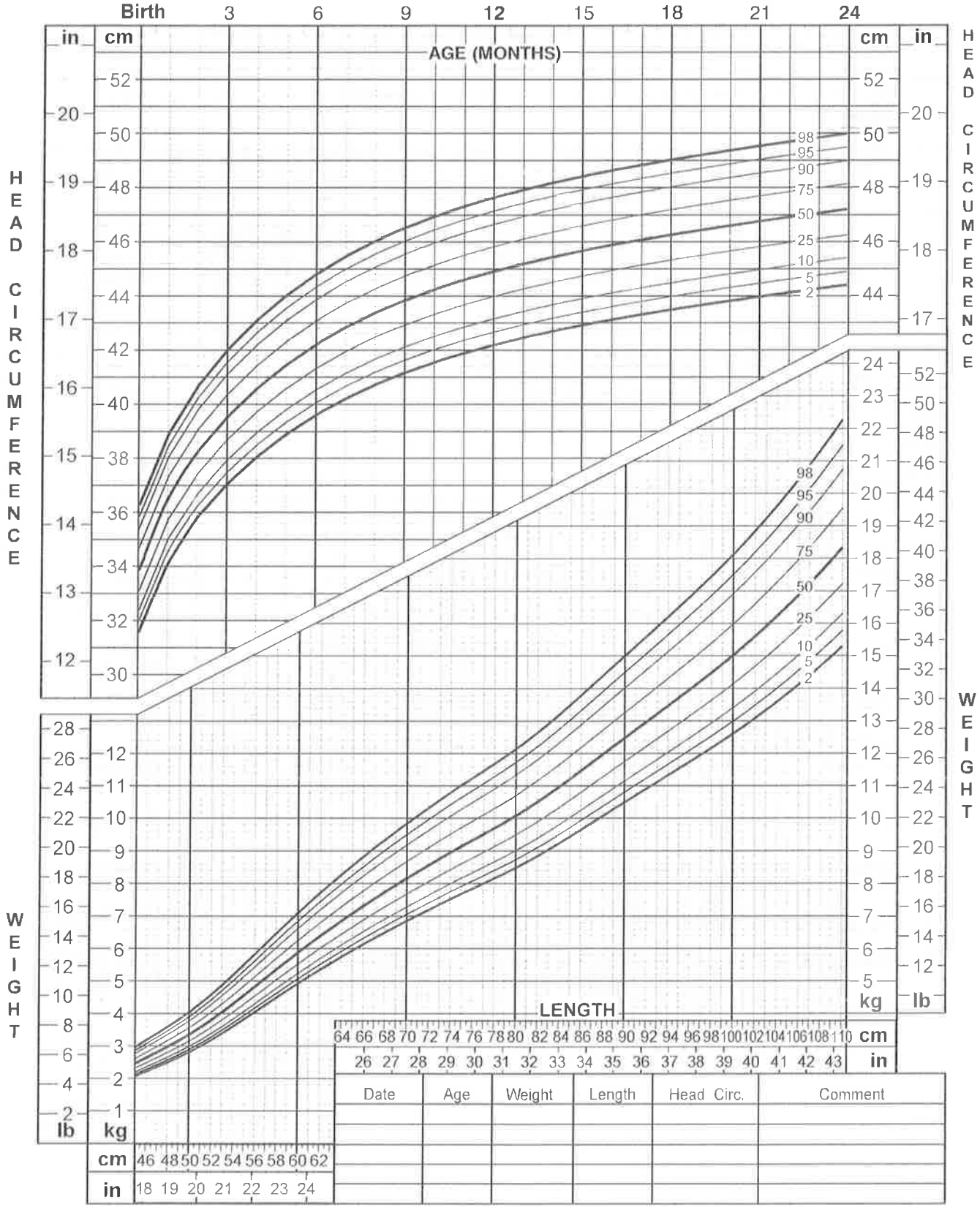
Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



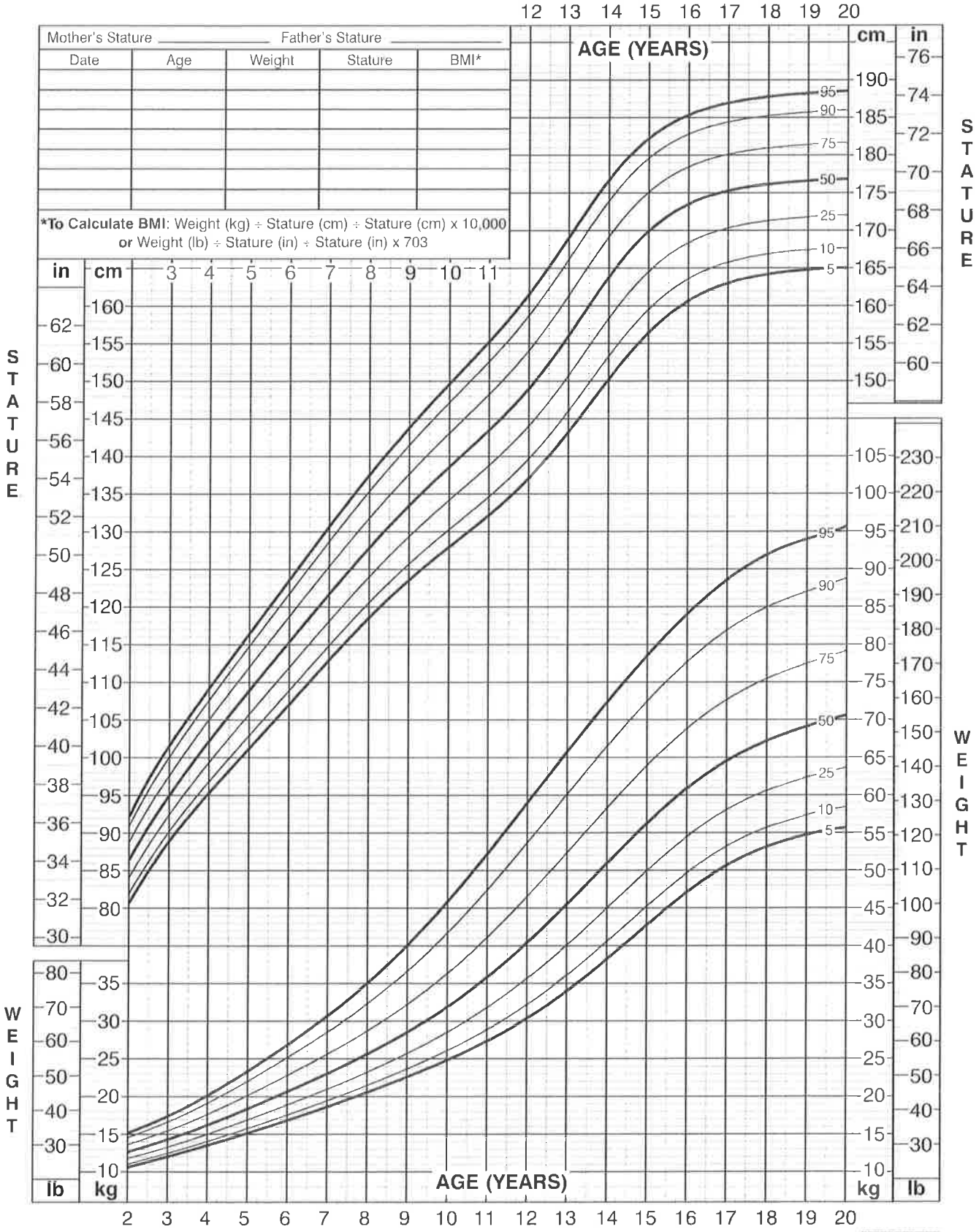
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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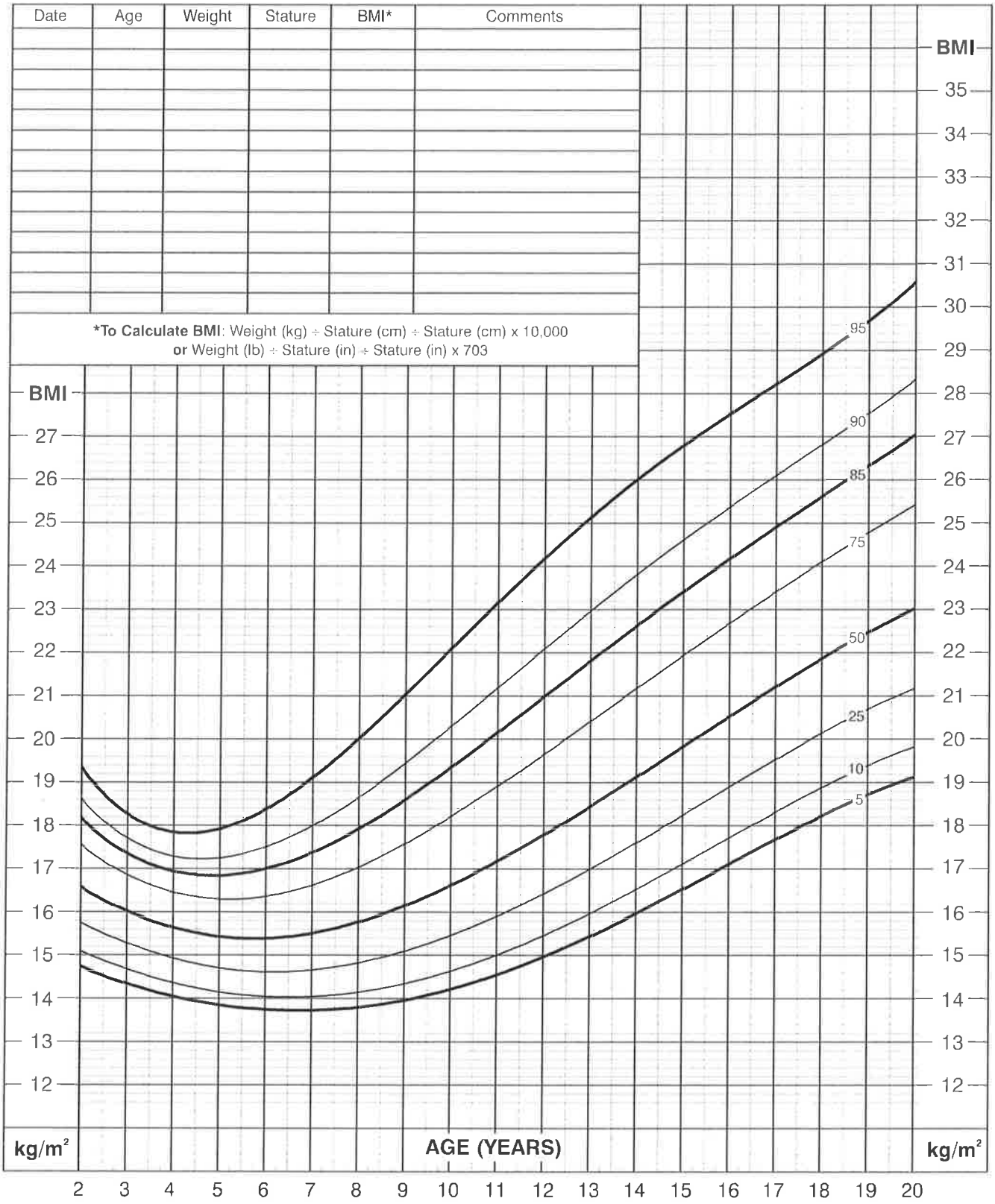
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

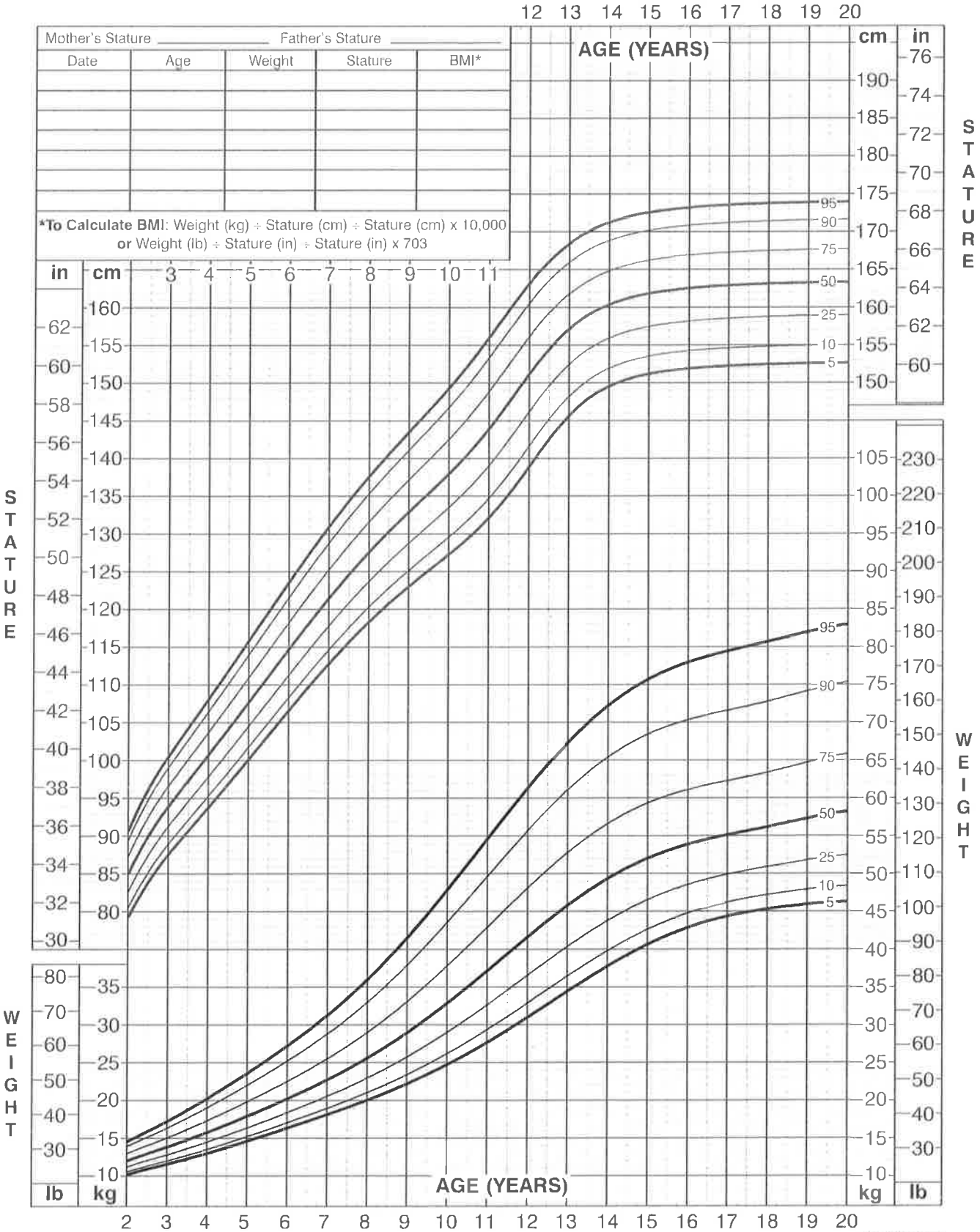
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER · HEALTHIER · PEOPLE

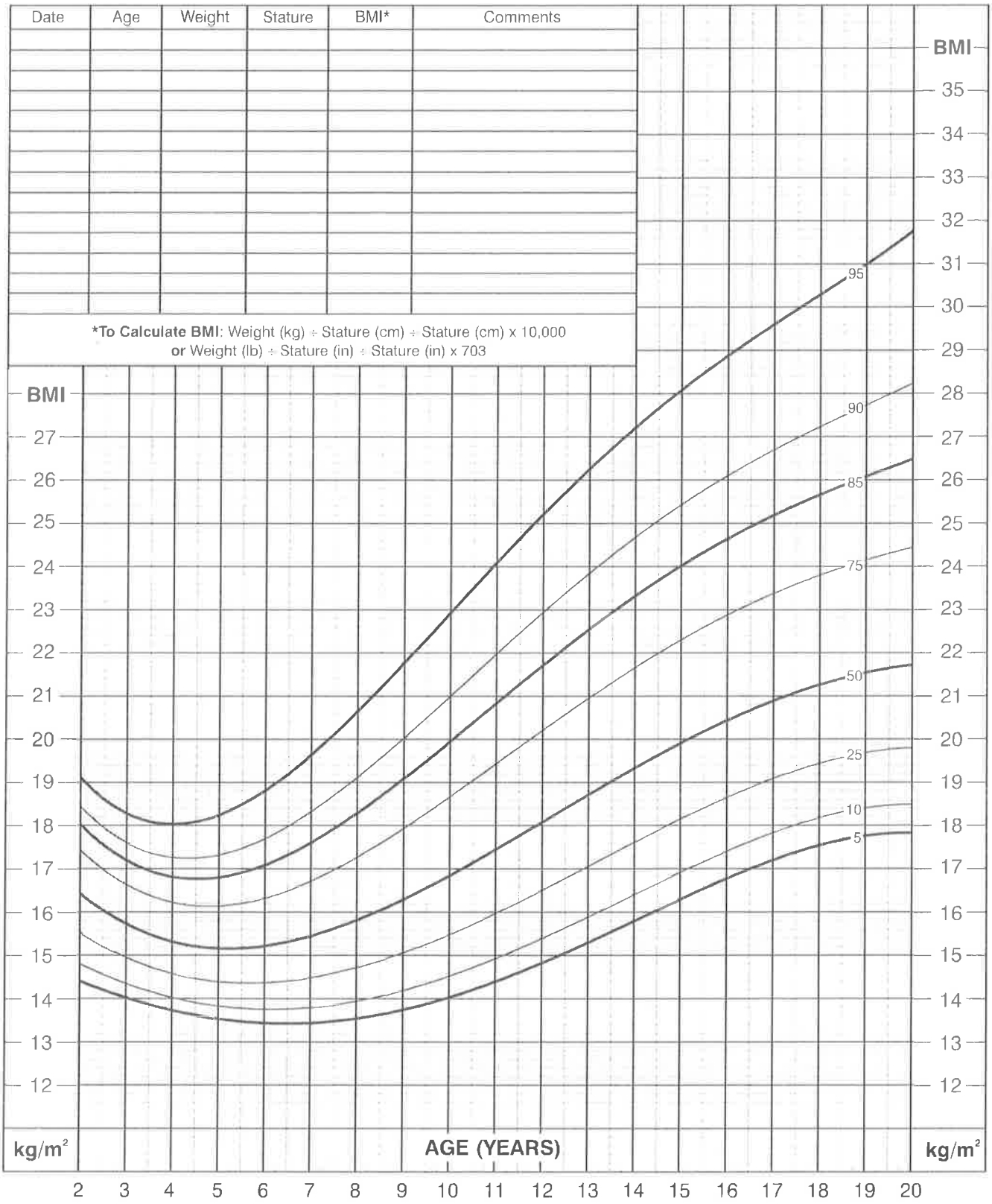
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
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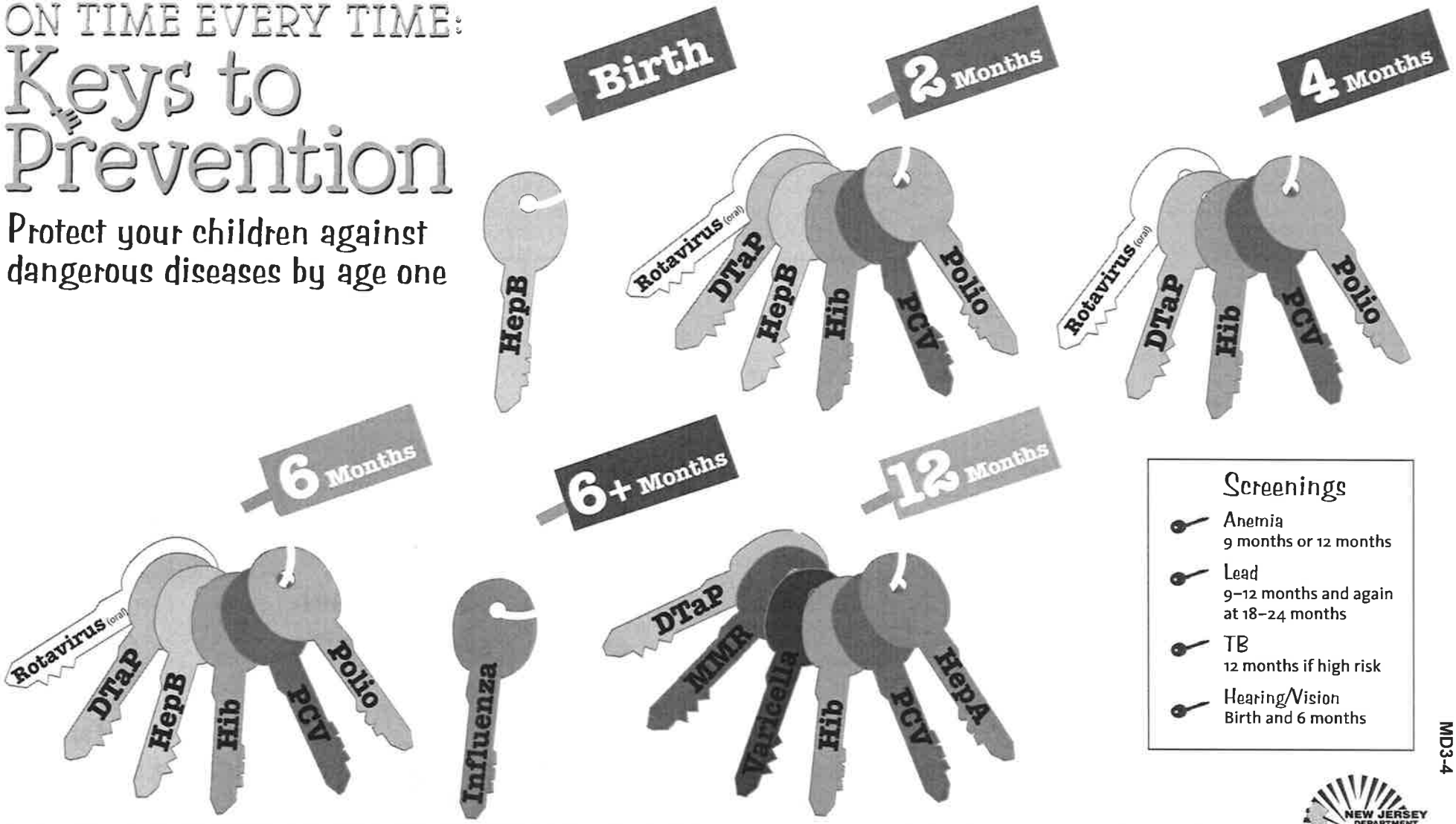
ON TIME EVERY TIME: Keys to Prevention

Protect your children against dangerous diseases by age one



MD3-4

New Jersey's Immunization Schedule is compatible with the current recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, and the American Academy of Family Physicians. For more information, please contact the New Jersey Vaccine Preventable Disease Program: 609.588.7512.

NEW JERSEY DEPARTMENT OF HEALTH SENIOR SERVICES

2016 Recommended Immunizations for Children from Birth Through 6 Years Old

Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
HepB	HepB			HepB						
		RV	RV	RV						
		DTaP	DTaP	DTaP		DTaP				DTaP
		Hib	Hib	Hib	Hib					
		PCV	PCV	PCV	PCV					
		IPV	IPV		IPV					IPV
					Influenza (Yearly)*					
						MMR				MMR
						Varicella				Varicella
							HepA§			

Is your family growing? To protect your new baby and yourself against whooping cough, get a Tdap vaccine in the third trimester of each pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

SEE BACK PAGE FOR MORE INFORMATION ON VACCINE-PREVENTABLE DISEASES AND THE VACCINES THAT PREVENT THEM.

For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
http://www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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MD3-5

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

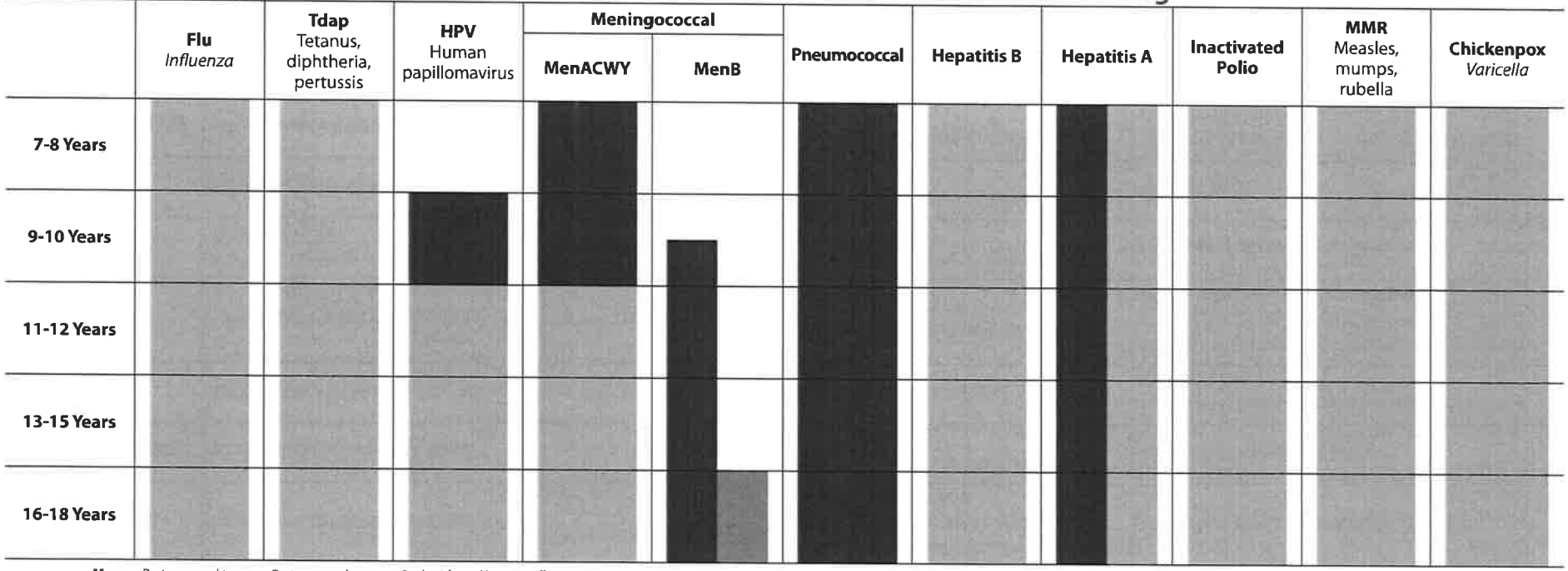
* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 2016 • CS261834-D •

INFORMATION FOR PARENTS

2016 Recommended Immunizations for Children 7-18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age.



More information:

- **Flu:** Preteens and teens should get a flu vaccine every year.
- **Tdap:** Preteens and teens should get one shot of Tdap at age 11 or 12 years.
- **HPV:** Both girls and boys should receive 3 doses of HPV vaccine to protect against HPV-related disease. HPV vaccination can start as early as age 9 years.
- **MenACWY:** **All** 11-12 year olds should be vaccinated with a single dose of a quadrivalent meningococcal conjugate vaccine (MenACWY). **A booster shot is recommended at age 16.**
- **MenB:** Teens, 16-18 years old, **may** be vaccinated with a MenB vaccine.

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

This shaded box indicates the vaccine is recommended for children not at increased risk but who wish to get the vaccine after speaking to a provider.

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MD3-6

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccination)
Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the diptheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccination)
Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccination)
Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

Human Papillomavirus (Can be prevented by HPV vaccination)
Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

Influenza (Can be prevented by annual flu vaccination)
Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccination)
Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by meningococcal vaccination)
Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing or kissing. Symptoms include nausea, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal bacteria also cause blood infections. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccination)
Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely results in decreased fertility.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccination)
Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by pneumococcal vaccination)
Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), bacteremia and sepsis (blood stream infection). Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage, hearing loss and limb loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccination)
Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, About 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

Rubella (German Measles) (Can be prevented by MMR vaccination)
Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccination)
Tetanus is caused by bacteria found in soil, dust, and manure. The bacteria enters the body through a puncture, cut, or sore on the skin. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. Tetanus mainly affects the neck and belly. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. One out of five people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccination)
Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your healthcare provider.

Last updated on 03/28/2016 • CS264259-A

Recommended Immunization Schedules for Persons Aged 0 Through 18 Years
UNITED STATES, 2016

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(http://www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)

American College of Obstetricians and Gynecologists
(http://www.acog.org)

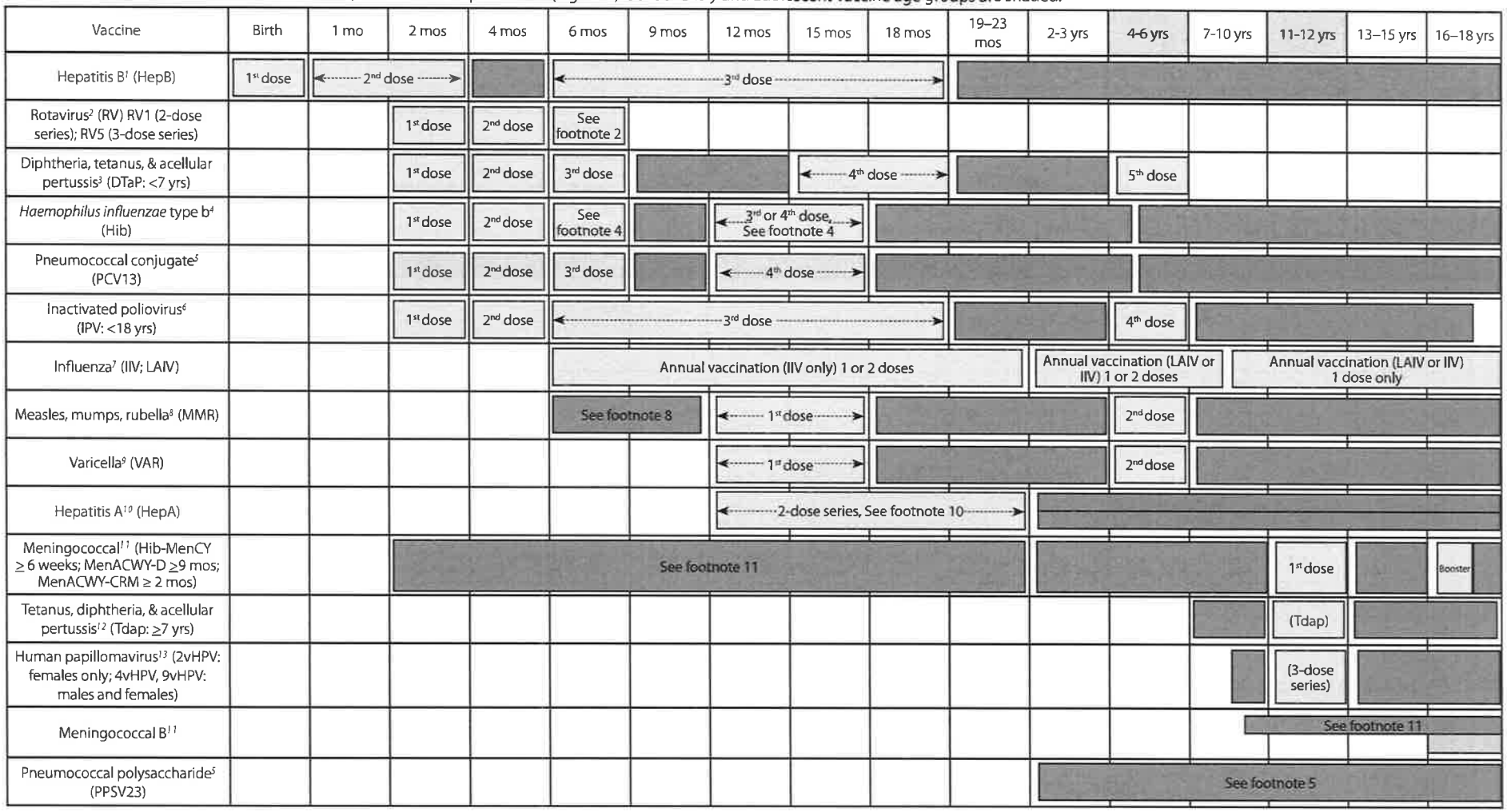
MD3-7

CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2016.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



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This schedule is approved by the Advisory Committee on Immunization Practices (http//www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B[1]	Birth	4 weeks	8 weeks *and* at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks *and* age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months (wait until at least 12 months old); OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday (wait until at least 12 months old). No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7months old. 8 weeks (as final dose for healthy children) if previous dose given between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6]	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[12]	7 years[12]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[13]	9 years	Routine dosing intervals are recommended.[13]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	4 weeks[6]	6 months[6]	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see *MMWR, General Recommendations on Immunization and Reports* / Vol. 60 / No. 2; Table 1. *Recommended and minimum ages and intervals between vaccine doses* available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.
- For vaccination of persons with primary and secondary immunodeficiencies, see Table 13, *"Vaccination of persons with primary and secondary immunodeficiencies,"* in *General Recommendations on Immunization* (ACIP), available at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.; and American Academy of Pediatrics. "Immunization in Special Clinical Circumstances," in Kimberlin DW, Brady MT, Jackson MA, Long SS eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the **first** dose. The final (third or fourth) dose in the HepB vaccine series should be administered **no earlier than age 24 weeks**.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])

Routine vaccination:

Administer a series of RV vaccine to all infants as follows:

1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:

- The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix, Quadracel]: 4 years)

Routine vaccination:

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (cont'd)

Catch-up vaccination:

- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up guidance, see Figure 2.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])

Routine vaccination:

- Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
- The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hiberix vaccine. Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.
- For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Catch-up vaccination:

- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If both doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered before the first birthday, the third (and final) dose should be administered at age 12 through 59 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
- For unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination of persons with high-risk conditions:

- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine (cont'd)**
   - Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.

   ** Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.*

5. **Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)**

   Routine vaccination with PCV13:
   - Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.
   - For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

   Catch-up vaccination with PCV13:
   - Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For other catch-up guidance, see Figure 2.

   Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
   - All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
   - For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
     1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
     4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
     5. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
   - For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
     1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
     2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
     3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
   - For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
   - A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)**

   Routine vaccination:
   - Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

   Catch-up vaccination:
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks) (cont'd)**
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age. If only OPV were administered, and all doses were given prior to 4 years of age, one dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
   - For other catch-up guidance, see Figure 2.

7. **Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])**

   Routine vaccination:
   - Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) persons who have experienced severe allergic reactions to LAIV, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunosuppressed persons; 6) children 2 through 4 years of age with asthma or who had wheezing in the past 12 months; or 7) persons who have taken influenza antiviral medications in the previous 48 hours. For all other contraindications and precautions to use of LAIV, see *MMWR* August 7, 2015 / 64(30):818-25 available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.

   For children aged 6 months through 8 years:
   - For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations, *MMWR* August 7, 2015 / 64(30):818-25, available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.
   - For the 2016-17 season, follow dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

   For persons aged 9 years and older:
   - Administer 1 dose.

8. **Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)**

   Routine vaccination:
   - Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
   - Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

   Catch-up vaccination:
   - Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

9. **Varicella (VAR) vaccine. (Minimum age: 12 months)**

   Routine vaccination:
   - Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

   Catch-up vaccination:
   - Ensure that all persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007 / 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

10. **Hepatitis A (HepA) vaccine. (Minimum age: 12 months)**

    Routine vaccination:
    - Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
    - Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    - For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

    Catch-up vaccination:
    - The minimum interval between the 2 doses is 6 months.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

10. Hepatitis A (HepA) vaccine (cont'd)

Special populations:

- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-FHbp [Trumenba])

Routine vaccination:

- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:

- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Clinical discretion:

- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:

Children with anatomic or functional asplenia (including sickle cell disease):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination at 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. Menactra
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properidin, factor D, factor H, or taking eculizumab (Soliris®):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

11. Meningococcal vaccines (cont'd)

3. Menactra
   - *Children 9 through 23 months:* Administer 2 primary doses at least 12 weeks apart.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj

- administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during a community outbreak attributable to a vaccine serogroup

- administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo, Bexsero or Trumenba.

For booster doses among persons with high-risk conditions, refer to *MMWR* 2013 / 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

For other catch-up recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see *MMWR* March 22, 2013 / 62(RR02);1-22, and *MMWR* October 23, 2015 / 64(41); 1171-1176 available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and http://www.cdc.gov/mmwr/pdf/wk/mm6441.pdf.

12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:

- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine vaccination:

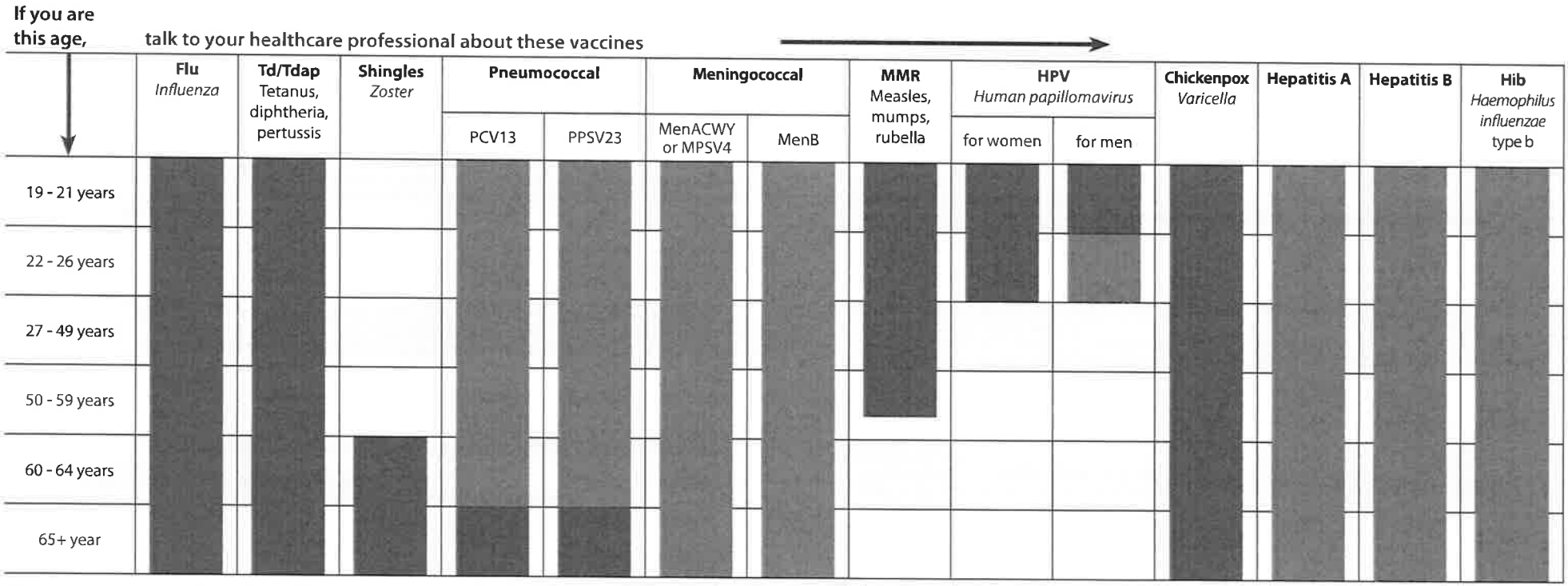
- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

Catch-up vaccination:

- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

INFORMATION FOR ADULT PATIENTS

2016 Recommended Immunizations for Adults: **By Age**



More Information:

- **Flu:** You should get flu vaccine every year.
- **Td/Tdap:** You should get a Td booster every 10 years. You also need 1 dose of Tdap. Women should get a Tdap vaccine during every pregnancy to protect the baby.
- **Shingles:** You should get shingles vaccine even if you have had shingles before.
- **Pneumococcal:** You should get 1 dose of PCV13 and at least 1 dose of PPSV23 depending on your age and health condition.
- **MMR, Chickenpox, Hepatitis A, Hepatitis B, Hib:** You should get this vaccine if you did not get it when you were a child.
- **HPV:** You should get HPV vaccine if you are a woman through age 26 years or a man through age 21 years and did not already complete the series.

Recommended For You: This vaccine is recommended for you ***unless*** your healthcare professional tells you that you cannot safely receive it or that you do not need it.

May Be Recommended For You: This vaccine is recommended for you if you have certain risk factors due to your health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

If you are traveling outside the United States, you may need additional vaccines.
Ask your healthcare professional about which vaccines you may need at least 6 weeks before you travel.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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INFORMATION FOR ADULT PATIENTS

2016 Recommended Immunizations for Adults: **By Health Condition**

If you have this health condition, talk to your healthcare professional about these vaccines →

If you have this health condition,	**Flu** *Influenza*	**Td/Tdap** Tetanus, diphtheria, pertussis	**Shingles** *Zoster*	**Pneumococcal**		**Meningococcal**		**MMR** Measles, mumps, rubella	**HPV** *Human papillomavirus*		**Chickenpox** *Varicella*	**Hepatitis A**	**Hepatitis B**	**Hib** *Haemophilus influenzae* type b
				PCV13	PPSV23	MenACWY or MPSV4	MenB		for women	for men				
Pregnancy														
Weakened Immune System			SHOULD NOT GET VACCINE					SHOULD NOT GET VACCINE			SHOULD NOT GET VACCINE			
HIV: **CD4 count less than 200**														
HIV: **CD4 count 200 or greater**														
Kidney disease or poor kidney function														
Asplenia (if you do not have a spleen or if it does not work well)														
Heart disease Chronic lung disease Chronic alcoholism														
Diabetes (Type 1 or Type 2)														
Chronic Liver Disease														

More Information:

- **Flu:** You should get flu vaccine every year.
- **Td/Tdap:** You should get a Td booster every 10 years. You also need 1 dose of Tdap vaccine. Women should get Tdap vaccine during every pregnancy.
- **Shingles:** You should get shingles vaccine if you are age 60 years or older, even if you have had shingles before.
- **Pneumococcal:** You should get 1 dose of PCV13 and at least 1 dose of PPSV23 depending on your age and health condition.
- **MMR:** You should get this vaccine if you did not get it when you were a child.
- **HPV:** You should get HPV vaccine if you are a woman through age 26 years or a man through age 21 years and did not already complete the series.
- **Hib:** You should get Hib vaccine if you do not have a spleen, have sickle cell disease, or received a bone marrow transplant.

For more information, call 1-800-CDC-INFO (1-800-232-4636) or visit www.cdc.gov/vaccines

Recommended For You: This vaccine is recommended for you ***unless*** your healthcare professional tells you that you cannot safely receive it or that you do not need it.

May Be Recommended For You: This vaccine is recommended for you if you have certain other risk factors due to your age, health, job, or lifestyle that are not listed here. Talk to your healthcare professional to see if you need this vaccine.

YOU SHOULD NOT GET THIS VACCINE

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS262412

FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS

NJ Health
New Jersey Department of Health

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

At this age the child should have received the following vaccines:	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**19 months**	**20-59 months**
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
Haemophilus influenzae type b (Hib)	Dose #1	Dose #2		1-4 doses* (see footnote)		At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses* (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1†			
Varicella (VAR)							Dose #1 §	
Influenza (IIV; LAIV)			One dose due each year ¶					

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

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* *Haemophilus influenzae* type b (Hib) and pneumococcal (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.
Please Note: The use of combination vaccines may allow students to receive the 1st birthday booster dose of Hib between 15-18 months of age.

† **MMR vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

§ **Varicella vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, a child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. Documented laboratory evidence showing immunity (protection) from chickenpox, 2. A physician's written statement that the child previously had chickenpox, or 3. A parent's written statement that the child previously had chickenpox.

¶ The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective

NJ accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, N.J.A.C. 8:57-4. Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

For more information, please visit "NJ Immunization Requirements Frequently Asked Questions", at the following link: http://nj.gov/health/cd/imm.shtml .

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Kindergarten-Grade 12 Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Guide for checking compliance
Step 1: Each child attending/enrolling must present documentation of immunizations or valid medical or religious exemption to vaccines. In order to allow a child to enter school, he/she must have at least one dose of each age-appropriate required vaccine.
Step 2: Determine child's present grade level.
Step 3: Compare the child's record with the requirements listed on the chart below.

Grade/level child enters school:		**Minimum Number of Doses for Each Vaccine**						
		DTaP Diphtheria, Tetanus, acellular Pertussis	**Polio Inactivated Polio Vaccine (IPV)**	**MMR (Measles, Mumps, Rubella)**	**Varicella (Chickenpox)**	**Hepatitis B**	**Meningococcal**	**Tdap (Tetanus, diphtheria, acellular pertussis)**
Kindergarten – 1st grade		A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses*	A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses*	2 doses†	1 dose	3 doses	None	None
2nd – 5th grade		3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Tetanus, diphtheria (Td)*	3 doses	2 doses	1 dose	3 doses	None	None
6th grade and higher		3 doses	3 doses	2 doses	1 dose required for children born on or after 1/1/98§	3 doses¶	1 dose required for children born on or after 1/1/97 given no earlier than ten years of age**	1 dose required for children born on or after 1/1/97 **

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Additional vaccines are recommended by the Centers for Disease Control and Prevention (CDC). The chart above lists only the vaccines that are required for school attendance in NJ. Please note that unvaccinated children, including those with medical and/or religious exemptions, may be excluded from school during a vaccine preventable disease outbreak or threatened outbreak to ensure public health safety.

For the complete CDC Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

* **DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5th dose) does not apply until the child attends Kindergarten. However, if one of these 4 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten. Children will need 5 doses if all doses were administered prior to the 4th birthday in order to enter Kindergarten.

Polio: Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4th dose) does not apply until the child attends Kindergarten. However, if one of these 3 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten.
Children will need 4 doses if all doses were administered prior to the 4th birthday.

† A child is required to receive two doses of measles, one dose of mumps, and one dose of rubella once he/she enters Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.
The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit http://nj.gov/health/cd/documents/antibody_titer_law.pdf.

§ Varicella vaccine is only required for children born on or after January 1, 1998. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as a parent can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

¶ Two doses of hepatitis B vaccine is acceptable if child received the vaccine between 11 – 15 yrs. of age AND the vaccine is identified as Adolescent Formulation.
Children who present documented laboratory evidence of hepatitis B disease or immunity, constituting a medical exemption, shall not be required to receive hepatitis B vaccine.

** Tdap and Meningococcal vaccines are required for all entering 6th graders who are 11 years of age or older; 6th graders < 11 years must receive Tdap and meningococcal vaccines once age 11 is reached.

For the complete list of "NJ Immunization Requirements Frequently Asked Questions", please visit http://nj.gov/health/cd/imm.shtml.

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State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

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December 1, 2008

N.J.A.C. 8:57-4.3 and 4.4 Immunization of Pupils in Schools rule,
Religious and Medical Exemption

The New Jersey Department of Health and Senior Services (NJDHSS) has received numerous inquiries regarding enforcement of N.J.A.C. 8:57 – 4, Immunization of Pupils in School. The issue of exemptions to mandatory immunizations has been reviewed by the NJDHSS Office of Legal and Regulatory Affairs and the New Jersey Office of the Attorney General. Below is a summary of the advice received from legal council regarding exemptions to immunization(s).

- Religious Exemptions:
  N.J.S.A. 26:1A – 9.1 provides an exemption for pupils from mandatory immunization "if the parent or guardian of the pupil objects thereto in a written statement signed by the parent or guardian upon the grounds that the proposed immunization interferes with the free exercise of the pupil's religious rights." All schools, child care centers, and local health officers may be advised that the religious exemption extends to private, parochial, and public institutions. When a parent or guardian submits their written religious exemption to immunization, which contains some religious reference, those persons charged with implementing administrative rules at N.J.A.C. 8:57 – 4.4, should not question whether the parent's professed religious statement or stated belief is reasonable, acceptable, sincere and bona fide. In practice, if the written statement contains the word "religion" or "religious" or some reference thereto, then the statement should be accepted and the religious exemption of mandatory immunization(s) granted. The language requiring how the administration of immunizing agents conflicts with the student's religious beliefs does not mandate specificity as to membership in a recognized church or religious denomination. NJDHSS will seek to amend the rules at N.J.A.C. 8:57 – 4.4 through the Administrative Rules process to be consistent with N.J.S.A. 26:1A – 9.1.

- Medical Exemptions:
  N.J.A.C. 8:57 – 4.3 allows for exemptions to immunizations which are medically contraindicated. A written statement shall be submitted to the school, preschool, or child care center from a physician licensed to practice medicine or osteopathy or an advanced practice nurse (certified registered nurse practitioner or clinical nurse specialist) indicating that an immunization is medically contraindicated for a specific period of time, and the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the Advisory Committee on

Immunization Practices (ACIP) or the American Academy of Pediatrics (AAP) guidelines.

Objections to vaccination based on grounds which are not medical or religious in nature and which are of a philosophical, moral, secular, or more general nature continue to be unacceptable.

NJDHSS hopes that the information provided will enable schools, child care facilities, and local health departments to process requests for exemptions in a more uniform and expeditious manner. NJDHSS remains committed to ensuring that our children and communities are protected against vaccine-preventable diseases. The dramatic decrease in the morbidity and mortality of vaccine-preventable diseases is attributed, in large part, to enforcement of school immunization requirements. The Department remains grateful for all the work expended locally to implement and enforce these important health regulations within the proscribed authority.

Chapter 4 Health Insurance for Children in Placement

Payment should never be an obstacle to accessing necessary care and treatment for a child in placement.

DCP&P provides Medicaid health insurance for all children in placement, regardless of their insurance status prior to entering placement. Resource parents must be provided a Medicaid number for any child placed in their home at the time of placement. This Medicaid coverage is the insurance used to cover all necessary care and treatment (in addition to all EPSDT evaluations). Any insurance held on behalf of the child prior to entering placement is suspended for as long as the child remains in placement. The only exceptions are for children receiving Medicaid as part of a Social Security or Disability payment. These children continue to receive their Social Security or Disability Medicaid in addition to the Medicaid coverage provided by DCP&P, and DCP&P reviews the necessity of the DCP&P Medicaid coverage as needed.

The State of New Jersey mandates that all recipients of Medicaid receive their health benefits through a Medicaid Managed Care Program of HMOs. Medicaid HMOs assist clients with managing their healthcare. In the HMO system, a primary care physician (PCP) is selected or assigned, and all routine care must be received through the PCP. In addition, referrals from the PCP may be required for specialty care.

For children in out-of-home placement, the Medicaid HMOs also provide for the assignment of a care manager from the HMO, who will work directly with the CHU nurse to assist resource parents/caregivers in coordinating services to best meet the medical needs of each child. HMOs will also work with DCP&P to ensure continuity of care for those children who were receiving other insurance benefits prior to entering placement. For those children who had Medicaid prior to entering placement, that transition is almost seamless.

There are currently five HMO options for Medicaid recipients. Resource Parents usually have the option of selecting the HMO of their preference (except in situations where the continuity of the child's care would be adversely affected), and should do so as soon as possible after a child is placed in their home. Children for whom an HMO has not been selected will be randomly auto-assigned into one. Not all five HMOs are available for use in all counties, so it is important that Resource Parents/caregivers are aware of what services are available within their county. The benefit package is the same for all the HMOs, and each HMO is required to develop networks of providers for both primary and specialty care. The Department of Human Services is the holder of the Medicaid

HMO contract, and is responsible for overseeing that Medicaid HMOs are in compliance with state mandates.

A list of resources and contact information regarding the HMOs is included in this manual (document entitled "*E-Z Medicaid Guide for Resource Parents*"). CASA volunteers, staff, and caregivers who need more information about Medicaid for children in DCP&P placement, or about enrolling in a Medicaid HMO, should consult this guide or speak to their DCP&P caseworker or CHU nurse.

Points of Advocacy for CASA

- The CASA volunteer should remember that payment should NEVER be an obstacle to accessing healthcare. While it may not be the particular provider or the particular type of device or treatment, it should be sufficient to provide basic treatment and care.
- The CASA volunteer should be sure that the child is enrolled in the HMO and has a Primary Care Physician (PCP), and should endeavor whenever practicable to keep that PCP in place even if the child moves placements.
- The CASA volunteer should ensure that their assigned child's caregivers have the child's Medicaid number so that they can easily access healthcare and obtain needed medications for the child, and that the caregivers have selected an HMO that offers services in their geographic area.
- If a child is not getting full coverage, the CASA volunteer should alert their staff supervisor, reach out to the child's DCP&P Caseworker, and then utilize the contact information in this manual.
- CASA volunteers should be mindful that there may be other avenues of funding beyond the coverage that the provider volunteers – CASA volunteers should talk to DCP&P about other funding sources if necessary (e.g., the catastrophic illness fund, county money, etc...) and be vigilant.

Manual Documents:

- E-Z Medicaid Guide for Resource Parents

E-Z Medicaid Guide for Resource Parents

Steps to access NJ FamilyCare (Medicaid) when a child first enters foster care:

1) Caseworker will provide the:
   Health Benefits Identification (HBID) Card Emergency Services Letter - This letter verifies the child's Medicaid eligibility and identifies the child's Medicaid number and HMO plan. It is valid until the end of the month. If the placement is made late in the month, you may be given two letters, one for the current month and one for the next month.

2) **Please call 1-877-414-9251 to request an actual HBID card for the child before the HBID letter expires. You will not receive another HBID letter beyond the initial eligible month(s).**
   - ❖ It may take up to 72 hours after placement before your information is verifiable within the Medicaid system
   - ❖ If you are a contracted Resource Provider, please contact the child's DCP&P caseworker to request the HBID card be mailed directly to your home, otherwise it will be mailed to your Agency, which could delay you receiving the card.

3) It is time to choose an HMO: A child in Resource Care is required to be enrolled in an HMO.

   - ➢ If the child being placed in your care is not already enrolled in an HMO, you must select one, or one will be automatically assigned for the child. **To select an HMO, call 1-800-701-0710.** Once selected, you will receive the child's HMO card as part of the new HMO enrollment packet.

   - ➢ If the child is already enrolled in an HMO, but does not have their HMO card at the time of placement, please call the HMO to have the HMO card mailed to you, and/or to request a new Primary Care Physician.:

United Healthcare Community Plan:	1-855-202-0713
Amerigroup New Jersey, Inc.:	1-800-452-7101
Horizon NJ Health:	1-800-682-9094
WellCare Health Plans of NJ:	1-877-334-2462
Aetna:	1-855-232-3596

   - ➢ If you want to enroll the child in a different HMO plan than what is identified in the HBID Letter, please call 1-800-701-0710.

4) Child going to vacation placement or being placed in a different home?
   Send the HBID and HMO cards with them! The cards are the child's property and should be with the child at all times.

Chapter 5 Continued Monitoring and Care for Children in Placement

Introduction

Children in out-of-home placement tend to have certain characteristics that are often associated with specific health problems, including asthma, lead exposure, obesity, and poor dental hygiene. In addition, biological factors, as well as trauma and historical factors, can lead to a variety of health issues (both mental and physical) for children in placement, such as Post Traumatic Stress Disorder or Complex Trauma Disorder.

While it is not the role of a CASA volunteer to diagnose medical, mental health or developmental issues, CASA volunteers should look out for any signs that their assigned child has specific health issue. Furthermore, if the child has already been diagnosed with a specific health issue, then the CASA volunteer should help to ensure that the appropriate treatment and medications are being provided and utilized. CASA pre-service training on Childhood Developmental Stages, as well as the *Pediatric Health and Red Flags* tools developed for DCF, should help a CASA volunteer understand what is to be expected in normal childhood development. They will provide a baseline for child development. To the extent that questions arise regarding a child's diagnoses, treatment, or medications, the CASA volunteer should consult his or her Case Supervisor (or other supervisory staff) as well as the DCP&P case worker and CHU nurse to address any such questions collaboratively.

Communication about a child's health care with biological parents, resource parents, or other caregivers is essential, especially at times of transition (whether interim transition or final transition to permanency). New Jersey has unique opportunities to improve communication among caregivers, foster children, and professionals providing care for children in placement. Ongoing communication among DCP&P case workers, CHU Nurses, medical clinicians, dental care providers, behavioral healthcare providers, and educational professionals working with children in placement is essential. Very often, CASA volunteers can help facilitate this communication.

Pediatric Health and Red Flags Tool

The *Pediatric Health and Red Flags Tool* was created by the Child Health Program. It is provided to CHU nurses and DCP&P caseworkers in order to assist

them with their assessments of children and families. The CHU nurses provide training to all new DCP&P caseworkers in the use of this tool.

As mentioned previously, the Tool provides a baseline for child development. For children 0-12, it covers what to expect at different ages in different domains (e.g., weight, nutrition, sleep, development, school, peers/friends, and well-child visits), as well as red flag to keep watch for. For youth ages 11-21, it covers slightly different domains but also includes suggested questions to ask the youth and caregiver, as well as red flags to keep watch for. Finally, the Tool covers mental health and related questions and red flags.

It is important to understand that this Tool is included in your manual to help you understand what is being used to assess the children to whom you are appointed. It is not your role to utilize the tool to assess the child; however, you can refer to it for baseline child development information and to help you identify any red flags which might require further communication with the caseworker. In fact, there will likely be times when you wish to use the Tool as a basis for a discussion with the caseworker or nurse, particularly where you have concerns about a child's growth, development, or medical or mental health needs.

Daily Medications for Chronic Health Issues

As a child is entering placement or changing placements, it is important to ask the biological parents and other caregivers (or an older child him/herself) **whether the child is on any daily medications, and ensure that the medications and any necessary equipment for giving the medications are provided to the resource parent.** Children may take daily medications for chronic illness (such as inhalers, spacers, or nebulizers for asthma, anticonvulsants for seizures, medications for diabetes or chronic infections such as for HIV). They may also take daily psychotropic medications for mental health conditions including ADHD, or special formulas or dietary supplements. Lapses in doses of regularly administered medications can lead to unnecessary hospitalizations and emergency room visits, seizures, or other complications.

Asthma and allergies are two common examples of chronic health issues requiring daily medication, as well as communication and planning. All people with asthma should have an Asthma Action Plan – a written plan developed with their healthcare provider to help control their asthma. Any person who cares for a child should be aware of that child's Asthma Action plan. This includes not only biological and resource parents, but also babysitters and workers at daycare centers, schools, and camps. A template *Asthma Action Plan* is included in this manual.

Similarly, while children and youth with seasonal or mild environmental allergies may respond well to either over-the-counter or prescription treatments, Anaphylactic Allergies or Reactions are of greater concern. This is a reaction that requires emergency treatment, usually with Epinephrine or other IV medication. Children or youth with any known anaphylactic allergic reactions (and their resource parents or other caregivers) should be provided immediately with an "EpiPen" in order to give an immediate dose of Epinephrine if the child/youth starts to have a reaction. An EpiPen should also be prescribed for school. The resource parent and the child/youth should be given instructions on how to use the EpiPen, how to store it, and how to carefully read labels and avoid inadvertent exposure to known allergens. Children with known anaphylactic reaction to insect stings should carry an EpiPen with them whenever outdoors, and likewise should have a MedicAlert Bracelet identifying the anaphylactic insect allergy. Similarly, medication allergies should be carefully discussed with a child's biological parent(s) and former primary caregivers, and should be noted in the child's Health Passport and all medical records.

Labels on prescription medication packaging will provide the prescribing clinician's name and the pharmacy where the medications were obtained. The pharmacy can provide physician contact information so that, if medications are about to run out, a new resource parent might obtain urgent or emergent refills. **However, a resource parent must be provided with a Medicaid number for the child being placed in their home at the time of placement in order to address chronic medication needs.** CHU nurses and/or DCP&P case managers can obtain a list of current medications from biological parents, as well as a list of previously involved specialists -- essential information that should be shared with a resource parent as soon as possible.

In this chapter, you will also find DCF's *Office of Child Health Services Psychotropic Medication Policy*. This document is the Department's statement of good practice for the treatment of children in out-of-home placement with psychiatric illness, who may require psychopharmacologic therapy as part of their treatment. This policy outlines the Department's basic principles, expectations regarding the development and monitoring of treatment plans, principles for informed consent, and principles governing medication safety.

Issues Particular to Teens and Adolescents

Access to medical care is one of the biggest challenges facing teens and adolescents in placement. It is absolutely critical that adolescents have a Medical Home where the adolescent feels welcomed and comfortable and where clinicians are well trained in providing care to teens, particularly to teens with

challenging and troubled histories. Most adolescents are best served by a pediatrician who is either an adolescent medicine specialist (most often found at Teaching Hospitals and in some practices), or a pediatrician or clinician with extra training or special interest in adolescents. A hospital emergency room or a walk in clinic in a drug store is NOT a Medical Home, though this may be where the teen has gotten his/her episodic medical care before going into placement.

It is important that the teens and their caregivers are educated about Medicaid and their HMO benefits, including choosing a provider, and understanding the need for referrals. DCP&P caseworkers can provide information to the teen and caregiver. The previous section of this manual also contains information about Medicaid. Additionally, some teens in out-of-home care may have chronic medical or mental health disabilities which may make them eligible for Supplemental Security Income (SSI), which provides more robust Medicaid coverage to meet their particular needs, and allows for a more seamless transition as they age out of the child welfare system. DCP&P, as legal custodian, is responsible for ensuring the completion and submission of the application for SSI.

It is not uncommon for teens and young adults to fail to recognize the need for on-going medical care, both preventive and therapeutic. CASA volunteers can support youth and teens in decisions about continuing good health care upon transitioning to independence/adulthood.

It is also not uncommon for teens in placement to engage in high-risk behaviors, placing them at risk for communicable diseases and chronic health care conditions. These high-risk behaviors include cigarette smoking, alcohol use/overuse, substance use/abuse (including prescription medications), unsafe sex (unprotected vaginal/anal/oral intercourse and/or sex with multiple partners). All teens should receive guidance on the dangers of these and other high-risk behaviors. CASA volunteers should collaborate with the teen's DCP&P caseworkers to ensure that this guidance and/or counseling is being provided.

Points of Advocacy for CASA

- The CASA volunteer's role is NOT to diagnose a child's condition, but to be familiar enough with the child to recognize when to seek additional information or ask additional questions. The first person that should be contacted with any question regarding a child's health is the CASA Case Supervisor (or other supervisory staff) – always reach out to supervisory staff first to discuss next steps.

- CASA volunteers can play an essential role as a hub for information from a variety of sources, and a partner to key stakeholders, including DCP&P caseworkers, physicians and clinicians, and caretakers.
- CASA volunteers should help ensure that their assigned child/youth has a Medical Home and that all medical records are up-to-date.
- If the child has any identified health issues, the CASA volunteer should be sure that the child's physician has taken care of any needed follow-up, re-testing, or treatment.
- CASA volunteers should be aware of any and all medications that their assigned child/youth is or should be taking, and should monitor (via follow-up with caregivers) whether those medications are being taken consistently and as directed.
- If the child is on medications to treat a mental health need, the CASA volunteer should be sure that there is a psychotropic medication treatment plan for the child and that it is being followed by the child and the caregivers.
- CASA volunteers should be sure that any child diagnosed with Asthma has an Asthma Action Plan, that all caregivers are aware of the Plan, and that it is being followed.
- Upon being assigned a case, the CASA volunteer should ascertain whether their assigned child has any life-threatening/anaphylactic allergies and, if so, should make sure that the caregivers of that child are made aware of such allergies, and that child has an EpiPen and a MedicAlert Bracelet (or similar identification).
- CASA volunteers working with teens should encourage them to be active participants in their own healthcare and health-related decision-making.
- If a teen is happy with a primary care office they have used in the past, try to continue care at that site throughout that teen's time in placement. This means you MUST ask the teen who their doctor is and was.

Manual Documents:

- Pediatric Health and Red Flags Tool
- The Pediatric/Adult Asthma Coalition of New Jersey Asthma Treatment Plan and Instructions
- NJ Department of Children and Families, Office of Child Health Services Psychotropic Medication Policy

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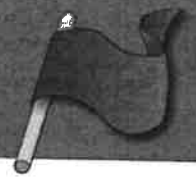

1

Family

Family

- Observe caregiver's mood, responsiveness, expectations and interactions with child
- How does the caregiver respond to the child's behavior?
- Does the caregiver listen to the child?
- Do they praise the child?
- How do they show affection?

Questions:

- Who is the child's primary caregiver?
- What are the extended family supports?
- What are the schedules?
- Who are the household members?
- Are there support services in the home?
- Does the child get along with children in the home and in other settings?
- Is the child in daycare or school?

Are preferences identified for:

- Health?
- Nutrition?
- Sleep?
- Discipline or setting limits?
- What is the primary language spoken in the home?

Red Flags:

- Lack of support
- Life changes
- Caregiver history of trauma
- Age
- Chronic illness
- Mood Disorders
- Depression
- Substance abuse
- Angry, fatigued, or overwhelmed
- Home schooling

Health Care Provider

Name

- Obtain names of Primary Health Care Provider, Dentist and Mental Health Specialists
- Location
- Telephone Number

Appointment Dates

- What was the date of the last visit?
- Is there a scheduled follow up visit?

Medications / Treatments

- Were there any medications/ treatments prescribed?
- What instructions were given?

- No Provider
- No Well Child Care
- No immunization record
- No Dental Care
- Multiple sick visits, ER visits or hospitalizations

Health Insurance

Name

- Obtain name of insurance and HMO

Number

- Obtain insurance number

Care Manager:

- Is there an assigned HMO Care Manager?

- No insurance

Anticipatory guidance

Infants:

- Never shake your baby
- Safe Sleep
- Tummy time
- Car Safety
- Secondhand smoke
- Choking risks
- Burns/hot liquids
- Water safety
- Sunscreen

Toddlers / Preschoolers:

- Firearms
- Poisoning
- Falls
- Burns and Fire Safety
- Drowning and Water Safety
- Car Safety
- Bike Safety
- Street Safety
- Sunscreen

School Age Child

- Firearms
- Fire Safety
- Water Safety
- Car Safety
- Bike Safety
- Street Safety
- Stranger Danger
- Sport Safety
- Peers
- Media use
- Tobacco/ Alcohol/Drugs
- Sunscreen
- Puberty
- Abuse Prevention

Adolescent / Young Adult

- Tobacco/ Alcohol/Drugs
- Pregnancy
- STDs/STIs
- Car/Bike Safety
- Sport Safety
- Firearms
- Violence
- Fire Safety
- Water Safety
- Street Safety
- Sunscreen
- Dating Safety
- Puberty

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Pediatric Health and Red Flags Tool

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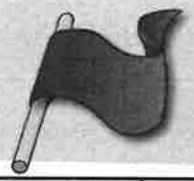

3

Infant	Birth – 2 weeks	2 Months	4 Months	6 Months	9 Months	12 Months	Red Flags
Weight • Validate weight with Medical Record • Ask what the infant's weight was at the last doctor's visit?	**6 lbs or greater**	**8 lbs to 14 lbs**	**11 lbs to 18 lbs**	**12 lbs to 21 lbs** • At least 2 times birth weight	**15 lbs to 24 lbs**	**18 lbs to 27 lbs** • At least 3 times birth weight	• Birth weight < 6 lbs • No weight gain • Weight loss • Excessive weight gain
Nutrition • Observe caregiver preparing formula and food • Observe caregiver holding, burping and feeding infant • Observe infant eating • Ask what the baby is fed, how much and how often • Ask about WIC • Does your baby let you know when (s)he is hungry? • Do you need to wake your baby for feedings? • How many hours does your baby go between feedings during the day?	**Breastfeeding:** • Nursing at least every 2-3 hours **Bottle feeding:** • Iron-fortified formula **Birth to 4 months:** • 8-12 feedings / day • 2-6 ounces / feeding • Do not give additional water or food without healthcare provider's permission. • Do not give food in bottle unless directed by health care provider. • At least 6-8 wet diapers per day.			**If breastfeeding:** • Nursing at least 5 times per day and once before bedtime **If bottle feeding:** • Iron-fortified formula • 4-5 feedings/ day • 28-32 oz / day • May sleep through night without waking for feedings • Introduce baby foods	**If breastfeeding:** • Nursing at least 3 times per day and once before bedtime. May no longer be breastfeeding exclusively. **If bottle feeding:** • Iron-fortified formula • 3-5 feedings / day • 7-8 oz / feeding **Baby Cereal:** • ½-1 cup per day **Vegetables, strained or mashed fruits:** • 2-4 jars (4 oz size) per day **Meats or mixed meals:** • Additional 1-2 jars per day **Juice** • Limited to 4 oz per day and does not replace formula or breastmilk **Eating 3 meals per day.** • Soft, mashed or chopped table foods can be introduced. • No honey, whole milk or eggs before 12 months	• Underfeeding • Overfeeding • Bottle propping • Baby bottle tooth decay • Improper formula/ food preparation • Table foods that are not safe for an infant • Honey, whole milk or eggs reported in diet

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Infant	Birth – 2 weeks	2 Months	4 Months	6 Months	9 Months	12 Months	Red Flags
Sleep • Look at where the infant is sleeping • What is the sleep routine and setting? • Ask about crying; how do you soothe your baby? • Ask about tummy time	• Newborns have different stages of sleep: deep, light, drowsiness, quiet alert, active alert, crying • Crying peaks at 6 weeks of age	• 5 sleep periods for a total of 13-14 hours / day • 8 hours at a time at night by 3 months	• 2-3 naps /day for total of 14 hours / day • By 6 months infant is able to let caregiver know when they are happy, hungry, need a diaper change, tired or not well.		• 2 naps / day for total of 12-14 hours of sleep per day 		• Co sleeping • Sleeping on soft surfaces • Colic • Difficulty falling or staying asleep • Too much or too little sleep • Head is an odd shape
Developmental Milestones • Observe infant while awake and hold infant • Ask the caregiver to tell you what the infant is doing now • Ask if the infant is receiving services from EIP 	• Fusses • Regards face • Responds to noise	• Coos • Smiles responsively • Tries to lift head when on tummy • Follows with eyes • Responds to noise	• Laughs • Responds to voice • Follows with eyes • Grasps Rattle • Turns head from side to side • Lifts head up all the way when on tummy	• Pulls to sit-no head lag • Reaches for objects • Smiles spontaneously • Rolls over • Babbles • Looks for source of sounds	• Grasps with thumb and finger • Imitates speech sounds • Sits without support • Holds own bottle • May drink from cup/straw • Starts to finger feed self 	• Walks around furniture • Stands holding on • Plays peek-a-boo • Bangs 2 cubes • Says "mama" and "dada" specifically	• Infant is not meeting the milestone at the expected age
Well Child Visits • Complete physical examinations • Validate that visit occurred with Medical Record / Collateral • Ask to see the immunization record and note date of last immunization • Have you needed to take the baby to the ER or a doctor for sickness?	• Well Visit 3-5 days after hospital discharge • 2 week well check • Developmental Screening	• 2 month well check • Immunizations • Developmental Screening	• 4 month well check • Immunizations • Developmental Screening	• 6 month well visit • Immunizations • Developmental Screening	• 9 month well check • Developmental Screening	• 12 month well check • Immunizations • Lead Testing • Developmental Screening	• No Well Child Care • No immunization record • Multiple sick visits, ER visits or hospitalizations • Prematurity • Twins and other multiples • Genetic disorders • Congenital defect • Substance exposure

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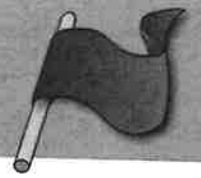

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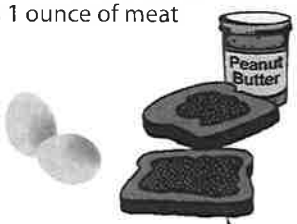
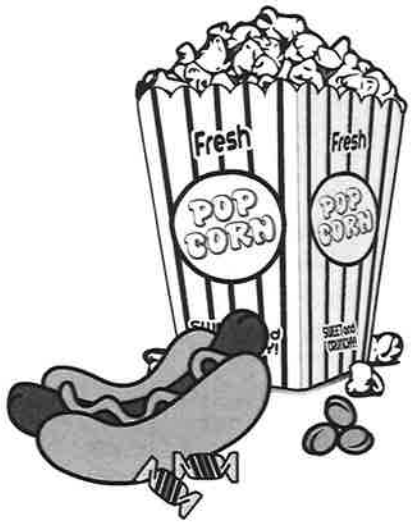
Toddler / Preschooler	15 Months	18 Months	2 Years	3 Years	4 Years	5 Years	Red Flags
Weight • Validate weight with Medical Record • Ask child's weight at last doctor's visit	19 lbs to 29 lbs	20 lbs to 31 lbs	22 lbs to 33 lbs • Average weight gain is 2-3 lbs / year	26 lbs to 38 lbs • Average weight gain is 2-3 lbs / year	30 lbs to 44 lbs • Average weight gain is 5 lbs / year	32 lbs to 52 lbs • Average weight gain is 5 lbs / year	• Weight loss • No weight gain • Excessive weight gain
Nutrition • Ask about the child's appetite • Ask if the child feeds themself • Where does the child eat? • How much milk does the child drink each day? • Does the caregiver report that the child is drinking too much or too little milk? • Does the caregiver report that the child is eating too many sweets? • Ask if the child has allergies • Ask if the child is receiving WIC • Ask if they brush their child's teeth	**3 full meals and 2 snacks that include:** **Milk and Dairy Products: 2-3 servings** • 1 cup milk or yogurt • 2 ounces cheese   **Meat, fish, poultry or equivalent: 2-4 servings** • 2-3 ounces of cooked lean meat, chicken or fish • ½ cup of cooked dry beans • 1 egg or 2 tbsp of peanut butter equals 1 ounce of meat  **Fruits: 2 servings** • 1 piece fruit • ½ cup canned fruit • ¼ cup of dry fruit • ¾ cup of juice  **Vegetables: 3 servings** • ½ cup of chopped raw or cooked vegetables • 1 cup of raw leafy vegetables  **Bread and grain: 3-5 servings** • 1 slice of bread • ½ cup of cooked rice or pasta • ½ cup of cooked cereal • 1 ounce of dry cereal *Fats and sweets should be limited*	**Unsafe Foods for Toddlers:** • Hot dogs • Hard candies, including jelly beans • Nuts • Chunks of peanut butter • Popcorn • Raw carrots, celery, green beans • Seeds, whole grapes, cherry tomatoes • Any large chunks of food  	• Unsupervised meals or snacks • Inappropriate foods • Pressuring child to eat • Force feeding • Gorging • Begging for food • Refusing food • Hoarding food • Pica • Dental Caries

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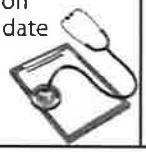
Pediatric Health and Red Flags Tool

Toddler / Preschooler	15 Months	18 Months	2 Years	3 Years	4 Years	5 Years	Red Flags
Sleep/Naps • Look at where the child is sleeping • What is the sleep routine? • Does your child have difficulty falling asleep? • What is your child's bedtime? • Does the child take a nap? • Is caregiver reporting that the child has nightmares?	• Needs about 13.5 hours / day, sleeping through night and taking 1-2 naps/day	• Needs about 13.5 hours / day, sleeping through night and taking 1-2 naps/day	• Needs about 13 hours/day, sleeping through night and taking 1 nap/day	• Needs about 12 hours/day, sleeping through night and taking 1 nap/day 	• Needs about 12 hours/day • May still nap • Nightmares may occur	• Needs about 12 hours/day • May still nap • Nightmares may occur	• Caregiver reports that child is not sleeping • Child refuses to go to bed • Lack of routine • Frequent nightmares • Night Terrors • Sleep Walking
Developmental Milestones • Talk to child, observe and note communication skills • Ask what new things the child is doing • Ask if the child is receiving services from EIP or CST	• Walks without support • Drinks from cup • Indicates wants by pulling or pointing • Speaks words in addition to "mama" and "dada"	• Walks well • Imitates housework • Speaks 15 words • Follows at least one simple direction • Removes clothes	• Begins to run • Points to 1 named body part • Walks up steps • Scribbles • Uses two-word sentences • Can pull up pants	• Jumps in place • Speech understandable • Copies circles • Washes hands • Dresses with supervision • Turns pages in a book	• Dresses self without supervision • Knows first and last name • Plays well with other children • Tells a story • Can brush teeth	• Separates from caregiver • Knows colors • Counts to 10 • Hops on one foot • Engages in conversation • Speaks clearly and can be understood • Understands simple rules	• Does not meet milestones • Loss of previously acquired skill • Language not clear • Excessive TV viewing
Toilet Training 	• May not be developmentally or physiologically ready		**Should begin to show signs of readiness:** • Dry for long periods • Signaling before voiding-looks into or grabs diaper, grimaces, crosses legs or squats • Hiding before defecating • Resisting toileting, toileting fears and stool refusal can be normal				• Persistent fear and refusal • Child-caregiver conflict
Well Child Visits • Validate that visit occurred with Medical Record • Ask to see the immunization record and date of last visit 	• Complete Physical Examination • Immunizations • Developmental Screening	• Complete Physical Examination • Immunizations • Developmen-tal Screening	• Complete Physical Examination • Immunizations • Lead testing • Developmental Screening	• Complete Physical Examination • Immunizations • Lead Screening • Vision exam • Dental exam • Developmen-tal Screening	• Complete Physical Examination • Immunizations • Lead Screening • Hearing exam • Vision exam • Dental Exam • Developmental Screening	• Complete Physical Examination • Immunizations • Lead Screening • Hearing exam • Vision exam • Dental Exam • Developmen-tal Screening	• No Well Child Care • No Dental Care • No immunization record • Multiple sick visits, ER visits or hospitalizations • Chronic health conditions • Elevated lead level

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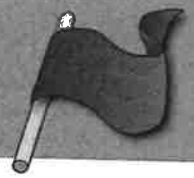
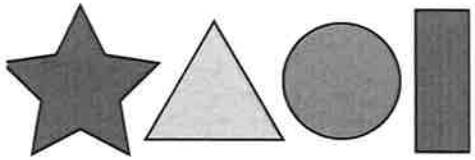
Pediatric Health and Red Flags Tool



7

School age children	6–8 years	9–12 years	Red Flags
Weight/Height • Validate growth parameters with Medical Record 	• May gain 4 -5 pounds per year • Grow on the average 2.5 inches per year • Boys and girls are similar in size	• May gain 4 - 8 pounds per year • Grow on the average 2.5 inches per year • May begin to develop secondary sexual characteristics and prepubescence • Wide variation in body shape and size between boys and girls • Girls are growing faster than boys at this time	• Excessive weight gain • BMI>85% • Weight loss • Small stature • Poor body image
Nutrition/Physical activity • What did the child eat in the past 24 hours? • Does the child have food allergies? • Does the child receive school meals? • Does the family eat meals together? • Is there a food group the family or child avoids? • What activity does the child participate in?	• 3 meals with 2-3 snacks per day • Milk and dairy products: 3-4 serving per day • Meat, fish, poultry or equivalent: 3-4 servings per day • Fruit and vegetables: 5 servings per day • Bread and grain: 5-6 servings per day • Limit sugar, fat, sodas and fruit juice • 1 hour of activity / day • Common to have unpredictable food patterns: ravenous appetite one day and finicky the next • May be over eating because of boredom or upset 		• Overeating and inactivity • Hoarding food • Unhealthy food restrictions • Begging for food
Sleep • What is the bedtime routine? • When is bedtime? Sleeptime? Waketime? • Does the child have trouble falling or staying asleep? • Do you hear your child snoring?	• 10-12 hours of sleep / night • Occasional nap • Problems falling or staying asleep are common because of homework, media use, or lack of bedtime routine • Time is needed to unwind		• Night terrors • Sleep walking • Enuresis • Snoring
Home/Family • Have there been any recent life changes? • How does the family spend time together? • How are limits set? • Does the child have responsibilities in the home? • How do family members get along?	• Child has age appropriate responsibilities in the home • Child understands family rules • As child develops independence, conflict and frustration may be normal • Older child has personal space in the home • Child knows safety rules for home and outside the home 		• Inappropriate discipline/ limit setting • Lying • Family stress and change • Parentified child

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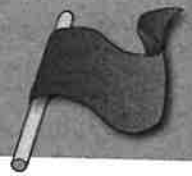
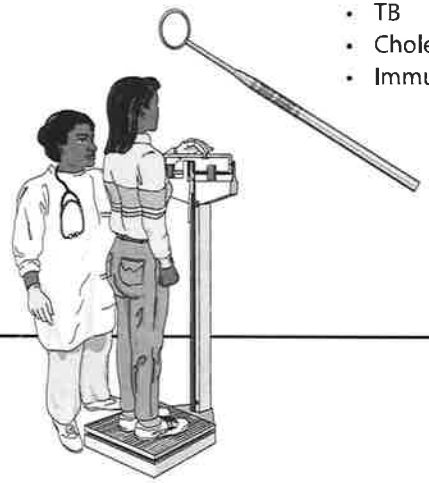
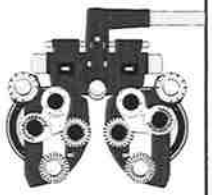
Pediatric Health and Red Flags Tool



School age children	6–8 years	9–12 years	Red Flags
School • What school does the child attend? • What time does the child leave for school? • How does the child get to and from school? • What time does the child arrive home from school? • What activities does the child participate in after school? • Does the child go home to an empty house? • How is the child doing in school? • Is homework completed? • Is there child / teacher conflict? • Does the child have an IEP?	• Child does their best in school • Reports liking school • Involved in school and after school activities • School reports child's progress/attendance • Parents have knowledge of child's progress and attends teacher conferences		• School phobia • Truancy • Absenteeism • Bullying • Cheating • Acting out in school • Grades dropping • Hyperactivity
Peers/Friends • Is the child able to make friends? • Does the child have a best friend? • How often does the child get together with friends/peers? • Are there any concerns about the child's friends/peer relationships?	• Positive peer relationships • Friends are welcome in the home • Parents know child's friends and their family • Parents have counseled child about alcohol, drug, tobacco and inhalants • Neighborhood safety		• Stealing • Lying • Bullying • Unsafe friends • Gang involvement • High risk behaviors
Well Child Visits • Review Medical Record 	• Complete physical exam • Hearing • Vision • Oral health • Anemia 	• Lead • TB • Cholesterol level • Immunizations 	• No immunizations • Multiple sick visits • ER visits • Hospitalizations 

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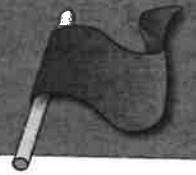

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Adolescent	Early 11-14 years	Middle 15-17 years	Late 18-21 years
Observations/Strengths:	**Questions for caregivers:**	**Questions for youth:**	**Red Flags:**
Growth/Nutrition/Physical Activity • Verify weight, height and BMI with medical record • Tanner stage (puberty/physical development) • Observe and question nutrition and daily exercise • Youth begins adolescence focused on bodily changes and should adjust to changes over time	• Do you have any concern about your child's weight, eating habits or activity? • How often do you eat meals together as a family? • What foods does your child like to eat? • Does your child get regular exercise?	• Do you have any concerns? • Tell me about the meals you eat. • What activities do you participate in? How often? • How much TV do you watch? • Do you use the computer at home? • How long do you stay on the computer?	• Reported weight changes • BMI <5% or >85% • Poor body image • Amenorrhea • Anorexia • Overeating • Purging • Hoarding food • Food restrictions
Well-being • Developing sense of identity • Self-esteem • Mood changes • Personal resilience	• How many hours of sleep does your child get at night? • Do you notice any stress in your child? • Are you ever concerned about the choices your child makes?	• What time do you usually go to sleep? • What time do you have to get up? • What worries you most?	• Changes in sleep pattern • Irritability/Nervousness • Sadness/Fearful • Past history of trauma • Risky behaviors • Withdrawn
Home/Family • Takes on more responsibility • Tests boundaries • Personal space	• Are you able to spend time together as a family? • Are there any tensions between you and your child? • What are the family rules?	• Do you still spend time with your family? • What is the time you spend with your family like? • What are your responsibilities at home? • Do you have personal space?	• Inappropriate discipline/ limit setting • Family stress/change • Lack of quality family time • Parentified adolescent • Lack of responsibility
Peers/Friends • Looks for peer acceptance • Invincibility • Healthy supportive relationships	• Do you know your child's friends? • Are you concerned about your child's choices of friends? • Where does your child go when not at home or at school? • What does your child share with you about their friends?	• Who are your friends? • Do your friends smoke, drink or use drugs? • Have they offered them to you? • Are any of your friends having sex? • Are you having sex? • Do you know how to protect yourself from STDs/STIs and pregnancy? • Do you ever feel pressure from your peers?	• Succumbs to peer pressure • Reports being bullied • Sexualized behavior • Inappropriate partner • Reports of unwanted sex • Unprotected sex • Gang involvement • Excessive cash

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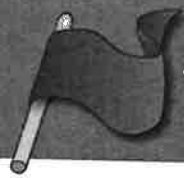
Pediatric Health and Red Flags Tool



Adolescent	Early 11-14 years	Middle 15-17 years	Late 18-21 years
Observations/Strengths:	**Questions for caregivers:**	**Questions for youth:**	**Red Flags:**
School/Future • Mastering life skills • Sets career goals • Transitioning into adulthood	• How is school going for your child? • How are your child's grades? • Is your child having any problems in school? • How do you help your child cope with the stress of school? • Have you and your child discussed future plans?	• Are you going to school? • What time do you get to school? • How is school going? • Do you have a job? • What are your plans for the future?	• Truancy • Bullying • No future plans • Loss of employment • Excessive cash
Adolescent Healthcare • Complete physical exam and dental care • Rights to confidentiality • Screening could include: • Vision and hearing screening • Lab work • TB • Immunizations • STDs/STIs • Pregnancy • Pap smear • Substance use	• When was your child last seen by the doctor? Dentist? • Does your child see a specialist? • Does your child have any health problems?	• Who is your doctor? Dentist? • Do you make your own appointments? • Does your doctor give you time to speak privately? • Do you have any special health care needs? • Do you take any medications? • Are there any healthcare issues that you do not share with your parents?	• Youth refuses medical treatment • Does not follow-up with appointments

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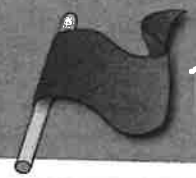
Pediatric Mental Health and Red Flags Tool



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Observations	Questions	Records	Strengths	Red Flags
Physical Health: • Physical appearance • Somatic complaint • Positive or negative changes in appearance	• What was the date of child's last well child care visit? • What was the date of the child's last specialist visit? (psychiatrist, neurodevelopmentalist, neurologist) • Do you have any pains or difficulty breathing? • Is there a scheduled follow up visit?	• Obtain Medical record • Obtain vital signs • Plot growth parameters and calculate BMI • Obtain copies of baseline labs/EKG	• Receiving recommended well child care • Recommended baseline testing completed • Maintaining growth parameters • Age appropriate development and communication skills	• Weight loss • Weight gain • Not maintaining growth parameters • Unable to communicate needs • Negative changes in labs
Nutrition • Eating habits • Physical appearance	• What did you eat yesterday? • Has there been a change in your weight? • Do you use meal supplements or sports drinks?	• Review record for nutritional recommendations and vitamin prescribed • Recommend child / family complete a food diary	• Healthy eating habits • Family meals 	• Reports concerns about body and body image • Overeating • Loss of appetite
Rest / Sleep: • Child appears tired • Restlessness • Hyperactivity 	• What is your bedtime? • Do you have difficulty falling or staying asleep? • Do you get drowsy during the day? • What is your wake up time? • Do you wake frequently during the night? • Do you have nightmares?	• Review school record for reports of falling asleep in school 	• Routine for sleep 	• Lack of routine • Frequent nightmares • Night terrors • Sleep walking • Problems getting to sleep and / or staying asleep
Home / Family • Observe mood in the home • Observe family interaction and communication	• What does the family do for fun? • Have there been any changes at home? • Ask child to tell you how they feel at home • Ask child to tell you about their caregiver and other children in the home	• Complete mental health screening • Review available mental health assessment	• Family time • Positive relationship with caregiver and siblings • Caregiver supports friendships, praises child and sets limits	• Conflict • Lack of support • Recent changes at home • Tense communication between child and family members
School / Community: • Child expresses positive interest in school • Reports missed assignments, trouble with teachers, or frequent tardiness	• In school what do you do well in? • What do you struggle with? • Do you have problems concentrating in school? • What do you do after school? • Has the school offered you additional help?	• Review school record for progress, grades, attendance, concentration • Place of employment	• Successfully transitioning through school with success • Extracurricular activities • Employment	• Truancy • Teacher conflict • Grades are dropping • Boredom • Loss of interest • Frequent tardiness • Aggressive behavior at school • Being fired from job

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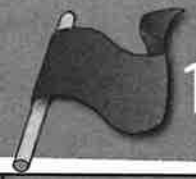

12

Observations	Questions	Records	Strengths	Red Flags
Peers: • Parents encourage friendships • Listen in conversation for accounts of friendships • Frequent texting / receiving phone calls	• What do you think of your child's friends? • How many friends do you have and who would you call your best friend? • What do you like to do with your friends? • Do your friends ever pressure you to do things you do not want to do? • Tell me about your job	• Review school and mental health assessment for positive peer relationships	• Making friends 	• No friends • Reports bullying • Unsafe friendships
Behavior-Mental Health • Unable to sit still • Interrupts conversation • Restless or hyperactive • Withdrawn	• What does your child do that makes you proud? • How does your child act when they are angry, frustrated, stressed or sad? • Ask caregiver about behavior at home • Ask child how they are doing at home	• Complete mental health screening • Review mental health assessment or school record for behavior • Review mental health history	• Screening does not indicate a need for mental health assessment	• Failure to thrive • Repetitive self- soothing behaviors • Loss of previously learned skill • Irritability • Outbursts • Aggression • Withdrawn • Suicidal gestures, thoughts
Psychotropic Medications: • Medication is targeting the symptoms indicated in psychiatric evaluation • No visible signs of medication side effects • Frequency of medication changes • New medications or changes in prescription	• Tell me what you know about the medication you are on? • Tell me what you know about your diagnosis? • When do you take the medication? • How often do you take the medication? • Do you have any thoughts of harming yourself? Do you have a plan? • Do you think that the medication is working?	• Obtain prescriber's information • Review psychiatric evaluation to see if medication fits diagnosis • Review record for medication changes • Verify diagnosis • Identify name, category, dosage and frequency of medication • Review consent and treatment plan	• Medication not indicated • Medication fits diagnosis and is treating target symptoms • No adverse effects from medications • Youth assents to medications • Youth understand diagnosis and indication for medication 	• Target symptoms worsen or there is no improvement • Child voices thoughts of harming self • Child not taking medications as prescribed • Child voices wanting to stop taking medications
Non-pharmacological Treatment: • Parent is using technique taught to address behavior	• Were you taught any techniques to help you control your feelings, behavior? • Ask child and caregiver if they know what to do in case of emergency • Is there a crisis plan in place?	• Obtain name of therapist and type of treatment prescribed	• Active participant in therapy • Has mentor • Therapy is meeting the needs of the child	• Refusing therapy • Services unavailable • Therapy not addressing child's issues
High Risk Behaviors: • Mood • Responsiveness • Attitude during visit • Appearance	• What do you do for fun? • Do you use any illegal substances? • Do you drink alcohol? • Do you smoke? • Are you sexually active?	• Review mental health assessment for reports of behavior	• None reported	• Substance use / abuse • Sexually active • Gang activity • Exposure to violence • Violent behaviors

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MD5-2

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

NJ Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ❑ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ❑ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ❑ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____
Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

REVISED AUGUST 2014

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ **I DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

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New Jersey Department of Children and Families
Office of Child Health Services

Psychotropic Medication Policy

January 14, 2010
(Revised May 17, 2011)

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Commissioner
NJ Department of Children and Families

Introduction

Children have the right to safety, respect, justice, education, health and well-being. As a society we have the obligation to protect these values for all of our children.

When children have been removed from their primary homes, whether due to abuse, neglect or other reasons, the state assumes the primary responsibility to safeguard these rights for the children in their care.

The Department of Children and Families (DCF) is New Jersey's state child welfare agency. Through direct services and community contracts DCF is focused on strengthening families and achieving safety, well-being and permanency for all New Jersey's children.

The Department's core values include safety, permanency and well-being. The Division of Youth and Family Services ensures children's safety and works to promote the ability of families to maintain children's safety within their own homes. The Division of Child Behavioral Health Services contracts for and coordinates a range of services that provide behavioral health services to all children in New Jersey according to their needs.

The DCF Office of Child Health Services works with DYFS and DCBHS to ensure that children served by the Department receive high quality, coordinated services to meet their health care needs and assure their well-being.

Children and youth with psychiatric illness have the same right to treatment as children and youth with any other health care need. Respect for the dignity of the child and the family is a prerequisite for treatment. Recognition that the individual with a psychiatric illness has the same intrinsic value as any other person is essential to the work of the Department.

The DCF Psychotropic Medication Policy is a statement of good practice for the treatment of children in out of home care with psychiatric illness, who may require psychopharmacologic therapy as part of the child's treatment. This policy outlines the Department's:

- Basic principles;
- Expectations regarding the development and monitoring of treatment plans;
- Principles for informed consent; and
- Principles governing medication safety.

This Policy needs to be used in conjunction with the regulations contained within the NJ Administrative Code and the regulatory Manual of Requirements under the auspices of the DCF Office of Licensing, Child Care and Youth Residential Licensing and the DCF Office of Licensing, Resource Home Family Licensing.

This is the Department's first comprehensive effort to address use of psychotropic medication. In this regard, we expect that the policy will evolve over time in response to changes in research and practice, as well as feedback from youth and families, providers, and the professional community, and will be informed by on going research and best practices. In developing this policy, the Department reviewed the work of the American Academy of Child and Adolescent Psychiatry (ACCAP), the American Academy of Pediatrics (AAP), the Annie E. Casey Foundation, the Child Welfare League of America (CWLA), and the policies of child welfare and mental health agencies in other states. The work products of these organizations have been incorporated throughout this document. DCF acknowledges the efforts of these organizations.

Application

This policy will have impact on two of the Department's operating divisions:

- The Division of Youth and Family Services (DYFS) is New Jersey's child protection and child welfare agency within the Department of Children and Families. Its mission is to ensure the safety, permanency and well-being of children and to support families. DYFS is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment.

- The Division of Child Behavioral Health Services (DCBHS) serves children and adolescents with emotional and behavioral health care challenges and their families. DCBHS is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment.

This policy applies to children who are in out of home placement through DCF, including children under the custody of DYFS who are in placement in a resource home or licensed congregate care setting, and any child in a DCBHS contracted residential treatment program, including treatment homes, group homes and residential treatment centers.

Although the focus of this manual is on psychotropic medication, the policy and guidelines are provided within the larger context of mental health care provided by the Department.

Basic Principles

This policy is grounded in the Department's values as expressed in the DCF Case Practice Model and DCF's Child Health Values.

DCF has identified essential core values and principles for working with children and families[1]. These values are:

- Safety: Child safety and health is paramount in our work, and children are, first and foremost, protected from abuse and neglect.
- Permanency: Children do best when they have strong families, preferably their own, and when that is not possible, a stable relative, foster or adoptive family.
- Well-Being: We will offer relevant services to children and families to meet their identified needs and promote children's development, education, physical and mental health.
- Most families have the capacity to change with the support of individualized service responses.
- Where possible, children should be placed in the least restrictive setting within their own communities.
- Government cannot do the job alone; real partnerships with people and agencies involved in a child's life – for example, families, pediatricians, teachers, child care providers - are essential to ensure child safety, permanency and well-being, and to build strong families.

Child health is a critical part of the recent child welfare reform efforts in New Jersey. Reform efforts around child health, including this manual are grounded in the DCF's child health values[2]:

- *Child centered care*: Care should be provided in a manner sensitive to the child. When possible, adolescents should be a part of their health care planning.
- *Continuity* of care for children is important and DCF strives to strengthen coordination across systems of care in support of transitions—transitions coming into care, during care, and transitions to permanency.
- *Access* to providers who have the capacity to serve our children, and accessing providers within timeframes that meet the needs of children is critical.
- *Quality:* DCF expects its children to receive high quality healthcare, inclusive of physical, mental/behavioral, and dental health.
- *Integration*: The health care needs of a child need to be integrated into services to the child as a whole.
- *Partnership:* DCF recognizes that to operationalize our child health values the partnership and collaboration of many in our communities is required.

Treatment Plan

Children who have a mental health need require a variety of interventions to manage their symptoms and develop appropriately. A formal treatment plan is the culmination of the

[1] New Jersey Department of Children and Families Case Practice Model
[2] NJ DCF Coordinated Health Care Plan For Children in Out of Home Placement

treatment team's work to identify the problem, specify target symptoms and treatment goals, develop interventions that are realistic for the child and family, and provide for reassessment. It represents an agreement to work together toward a mutually agreed upon set of goals.

The treatment plan is developed in collaboration with the child and family based on the findings of the health professional. It is the expectation of the Department that the child or youth who is the focus of treatment be an active partner in the treatment planning process. The unique abilities of the child and the family to learn and change need to be considered in developing a plan that will work. Consideration must also be given to the range of settings that the child is involved in – home, school, work, sports and clubs – to assure that the treatment plan is flexible and robust enough to serve the child across settings.

The treatment plan is guided by the principle that interventions should be child focused and family centered. The interventions that are selected are chosen based on the child's diagnosis, the strengths and needs that the child and family bring to the treatment process, and the resources of the community.

A treatment plan should include appropriate behavior planning, monitoring of symptoms and medication effects, and on-going communication between the prescriber and the child, parents, resource family, caseworker, therapist, pediatrician and other members of the child's treatment team.

The use of psychotropic medication for children constitutes only one strategy within a larger treatment plan to provide for that child's safety and well-being. Except in rare instances –such as an acute psychotic break – medication should be considered only after other, less physiologically intrusive interventions have been tried. When it is necessary to prescribe psychotropic medication to treat a child, the medication should be integrated into the comprehensive treatment plan. The medication trial must be definitive, targeted at specific goals, and undertaken in collaboration with the child, caregiver, and other treatment team members.

Under no circumstances shall psychotropic medication be utilized for purposes of discipline or restraint or the convenience of staff members or resource parents.

Components of a Treatment Plan:

The development and execution of a treatment plan includes, but is not limited to, the following individuals: the child; the child's parents; the child's caregiver; the prescriber; mental health treatment providers; DYFS caseworker and/or Care Management Organization; Child Health Unit RN Health Unit, and teachers.

A treatment plan includes:

- The child's diagnosis;
- The child's baseline strengths and needs;

- Target symptoms – stated in practical and everyday language as agreed to by the child/family team;
- Treatment Goals – stated in a way that can be measured;
- Treatment interventions, including medications (if part of treatment plan). If medications are utilized, the dosage and medication monitoring schedule must be specified; and
- Periodic Review and Reassessment.

Psychotropic Medication

Psychotropic Medication

The identification of medications with demonstrated efficacy has increased the tools available to mental health practitioners to treat patients with psychiatric illness. These medications have reduced the morbidity and mortality associated with some illnesses and provided comfort and improvement in function to many. Nevertheless, medication is a physiologically intrusive intervention and so places an increased responsibility on the prescriber to be specific and prudent in recommending its use.

It is the express requirement of the New Jersey Department of Children and Families that psychotropic medication only be prescribed to the children and youth in its care as part of a comprehensive treatment plan that includes other therapeutic interventions and modalities.

Authorized Prescribers of Psychotropic Medication: Because of the complex medical and psychiatric needs of children in out of home placements, it is required that psychotropic medications for children in out of home placement only be prescribed by board certified or board eligible specialists in one of the following areas of expertise: psychiatry (child and adolescent recommended), neurodevelopmental pediatrics, or pediatric neurology.

Advanced Practice Nurses (APNs) certified in Psychiatry/Mental Health, may prescribe psychotropic medication pursuant to a joint protocol with a collaborating board eligible specialist in one of the following areas of expertise: psychiatry (child and adolescent recommended), neurodevelopmental pediatrics or pediatric neurology, and as is set forth in N.J.A.C. 13:37-6.3, Standards for Joint Protocol between Advanced Practice Nurses and Collaboration Physicians.

A pediatrician or family physician, Board Certified Pediatric Advanced Practice Nurse, Board Certified Family Advanced Practice Nurse or Board Certified Psychiatric Advanced Practice Nurse may prescribe stimulant medication for uncomplicated Attention Deficit Hyperactivity Disorder. However, if that child is also being treated for another psychiatric disorder by another specialist, the prescriber must coordinate care with that professional.

Psychiatric Evaluation and Diagnosis

When the screening and assessment of a child's need for mental health services identifies the possible need for psychopharmacological intervention as part of the treatment plan, a thorough baseline evaluation is essential to the success of the intervention. With the exception of stimulant medication for uncomplicated ADHD, an initial evaluation and diagnosis by a psychiatrist, neurodevelopmental pediatrician or pediatric neurologist is required before the prescription of psychotropic medication. This baseline evaluation includes:

- History: The decision to treat with psychotropic medication should be based on a thorough mental health assessment and psychiatric evaluation that considers the individual's history including development, psychiatric history, medical history, past medications, allergies and drug reactions, and complete current medications including non-psychotropic medications. The contribution of physical illness or trauma history to the child's presentation must be considered. Consultation with other professionals who are treating the child, including teachers, therapists, primary care physicians, or medical specialists may be required.

  Psychiatric symptoms must be considered in the context of concurrent developmental and medical problems and medications.

- Physical Examination:
  As part of the decision to initiate a medication trial, a recent physical examination is required and must include height, weight, body mass index, and vital signs. When indicated by history, physical examination or psychiatric evaluation, the child may require medical specialty consultation and testing. Cardiac, endocrinological, neurological or other consultations might be indicated.

  Baseline laboratory assessment is advisable both to rule out subtle medical conditions that may contribute to symptoms, and to establish a baseline for possible adverse effect development. A negative pregnancy test should be obtained before initiating medication for a child/adolescent of child-bearing age. A baseline drug screen should be obtained when indicated.

  If the prescriber has not conducted this examination, the prescriber is to review the examination records.

- Mental Status Examination: The mental status evaluation of a child must be sensitive to the age, developmental stage and current status of the individual child. Child psychiatric diagnosis often requires multiple sessions to gain the trust of the child and allow for a clear picture of the youngster's mental status to be obtained. Ideally the child's history should be elicited first, and then the child interviewed both with and without parents or caregivers present. Often ancillary methods of assessment, including drawing and play therapy, may be required to elicit symptoms.

- Diagnosis: In developing a working diagnosis the prescriber must consider the child's symptoms, developmental history, medical history, family history, past experiences, current functioning in all settings, and current mental status.

- Goals and Target Symptoms: After a thorough assessment of the child's status has been completed, a working diagnosis is formulated, and specific target symptoms are identified. Target symptoms should be specific; when possible, they should be observable and quantifiable. The use of checklists to establish a baseline and monitor progress is recommended.

  The prescriber, child and caregiver should arrive at an agreement about the current severity and frequency of the target symptoms and agree on reasonable goals. It is important for the child and guardian to participate in the discussion of the target symptoms, as they will be the primary persons observing for pharmacological effect. Similarly, teachers and other professionals who have on-going contact with the child may be asked for their observations of medication effects.

- Initiating Medication: The decision to treat with psychotropic medication is guided by the child's diagnosis, strengths and needs, and considers the resources of the unique child, family and community.

  Medication decisions must be appropriate to the diagnosis of record, based on target symptoms. Medication must be prescribed as part of a treatment strategy that includes other non-pharmacological interventions, and may not be prescribed instead of instituting other non-pharmacological treatments that the individual child needs. Children and adolescents in state custody must have access to a range of effective psychosocial, psychotherapeutic and behavioral treatments as well as pharmacotherapy when indicated.

Informed Consent[3] and DCF Policy

Respect for the independence and autonomy of the child and family is implicit in the requirement for informed consent. It requires that the provider – mental health practitioner or prescriber – inform the patient of the risks and benefits of the proposed treatment and the risks and benefits of alternative treatments, including no treatment. By requiring that the provider discuss the treatment in terms that are understandable and adequate to the "reasonable man", the principle of informed consent underscores the necessity that the provider understand the patient and tailor the treatment to the individual.

Medication management requires the informed consent of the child's parent(s) or guardian(s) and must address risks and benefits of pharmacological treatment, the

[3] Informed consent is the requirement that any person who is the object of an intervention has the right to consent to or refuse treatment. When a treatment plan is developed in collaboration including the child, the caregiver and the treatment provider, the consent is built into the process of developing a treatment plan.

potential side effects, the availability of alternatives to medication, the child's prognosis with proposed medication treatment and without medication treatment, and the potential for drug interactions.

The prescriber must provide adequate information to the child, parent, caregiver and guardian for those persons to be able to make an informed choice to consent to medication. This includes information about the anticipated benefits of the medication, its possible risks, the range of doses, initial effects to anticipate, and what would constitute a reasonable trial. Written information should be supplied when available and in the primary language of the family. Information about serious adverse effects to watch for and when and how to contact the prescriber must be discussed. Families and guardians should be provided ample time for questions and discussion before consent is requested.

Prescribers must first seek consent from birth parents or legal guardians. In the absence of parental consent for children who are in out of home placement and under DYFS supervision, DYFS may only consent:

- When parental rights have been terminated;
- A court has provided specific authority to DYFS; or,
- In an emergency and the parents are unavailable.

Children: Children should be included in the discussion about initiating medication. When appropriate by age and mental status they should be included in the consent process.

Medication Safety Guidelines for Prescribers

Every child or adolescent has unique needs that require individualized treatment planning. It is the intent of the Department of Children and Families that children subject to this policy receive necessary mental health care, including psychotropic medications, in a rational, safe and timely manner.

The following represent guidelines for prescribers for prudent and rational psychopharmacological treatment of children and adolescents. In addition, these Guidelines are meant to be utilized by Department of Children and Families' staff to assist in the management of the Informed Consent process and the active participation in treatment plan meetings. The rationale for this treatment must be documented in the child's health record and be thoroughly reviewed during treatment team meetings.

- Preference is given to beginning with medications that have been FDA approved for a child's given age group and diagnosis before progressing to other medications.
- Medications that have more data regarding safety and efficacy are preferred over newly FDA-approved medications. Unless compelling reason exists to do otherwise, a child should have a trial of an FDA approved medication before

being prescribed medications that have not been approved for use in the pediatric population.

- Medication dosages should be kept within FDA guidelines (when available). Any deviation from FDA guidelines is to be documented with the underlying rationale in the child's treatment records.
- Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered.
- The use of two or more medications for the same symptom or disorder is discouraged and requires specific documentation, from the prescriber, in the child's health record. An exception to this principle is when a short acting form of a stimulant is used to augment the benefits of a long acting preparation.
- Only one medication should be changed at one time. This allows the prescriber to attribute changes to the medication change. An exception to this principle is when a child is being tapered off one medication and onto another.
- Medications should be initiated at a low dose and increased gradually. The clinical wisdom, "start low and go slow" is particularly relevant when treating children in order to minimize side effects and to observe for therapeutic effects.
- The decision to treat a child with more than one medication from the same class (e.g. two anti-psychotic medications) should be supported by written documentation in the child's health record from the prescriber and may warrant review by the DCF's Child and Adolescent Psychiatrist.
- A clinician prescribing more than 3 psychotropic medications to one child must justify and document the rationale for doing so in the child's treatment plan and may warrant review of the DCF's Child and Adolescent Psychiatrist.
- There should be an effort, over time, to adjust medications doses to the minimum dose at which a medication remains effective and side effects are minimized.
- Periodic attempts at taking the child off medication should also be tried and, if not, the prescribing clinician is to document the rationale for continuing the medication in the child's treatment plan.

Monitoring Guidelines

Assessment does not end with initiation of medication. According to best practices which shall be used when monitoring children, once a drug is prescribed, the prescriber must ensure its availability to the child, monitor his or her response, maintain a documentary record of treatment, and review medication use.

Frequent follow-up with the patient and caregiver is essential to an adequate medication trial and the safe administration of medication. On-going assessment of medication tolerability, progress toward goals, functioning in a variety of settings are all re-evaluated over time. The child's progress – or failure to progress - over the course of medication may suggest the need to re-consider the diagnosis.

Initiation/Medication Trial

A child on psychotropic medication should be seen by the prescriber at least once a month when the medication is initiated and until a stable dose and effect is reached. The

child's mental status, response to medication, progress toward treatment goals, any adverse effects, and symptoms of risk (for example, suicidal or homicidal ideation, inappropriate behavior, aggression) should be assessed and documented. Baseline assessments of height, weight, body mass index should be measured and plotted on a growth chart. (This may be done in coordination with the child's pediatrician.) Heart rate, respiratory rate and blood pressure should be measured. If the medication requires other measures, these should be considered at each visit.

If laboratory tests are indicated to monitor therapeutic levels of a medication or are needed to monitor potential organ system damage from a medication, they are to be performed according to recommended guidelines until a baseline is achieved.

Maintenance Phase

Once a child is stabilized on a medication the prescriber should see that child no less often than once every three months. Children in acute settings, displaying unsafe behavior, experiencing significant side-effects, or not responding to a medication trial or in an active phase of a medication trial should be seen more frequently.

If laboratory tests are indicated to monitor therapeutic levels of a medication or to monitor potential organ system damage from a medication these lab studies should be performed every three months at a minimum.

Discontinuation Phase

Except when a child's health and safety are at risk, medications should be discontinued slowly to allow the child to adapt to physiological change. The possibility of discontinuation syndrome and re-emergence of initial symptoms should be considered.

For Appendix A (NJDCF Psychotropic Medication Monitoring Guidelines) and Appendix B (Psychotropic Medication Prescribing Parameters), please visit:

http://www.nj.gov/dcf/documents/behavorial/providers/PsychotropicMeds.pdf

Chapter 6 Pulling it All Together – CASA Medical Advocacy

Introduction

As stated at the beginning of this training, the primary goal of CASA Medical Advocacy is to ensure that children receive any and all healthcare needed to keep them in optimal health while they are in out-of-home placement. This includes regular well-care, dental care, and immunizations, as well as any other necessary healthcare services while they are in out-of-home placement. With the support of your CASA Case Supervisor (or other designated staff), you -- the CASA volunteer -- should use your investigative and advocacy skills to:

- Gather information regarding the child's health status, immunizations, assessments, and care provided to the child. This may include not only gathering information, but also filling in information gaps.
- Help to ensure that any/all specific healthcare needs of the child are being met (including provision of regular well-care, dental care, and immunizations).
- Provide the Court with timely, objective, and unbiased information as gathered; this will allow the Court to make well-informed decisions on the child's behalf.

Information Gathering and Records Review

The information gathering process may be as simple as reviewing a complete DCP&P office file AND requesting and reviewing the Health Care Case Management (HCCM) Record. As noted in Chapter 2, the HCCM Record is maintained by the Child Health Unit; however, it must be requested from the DCP&P caseworker. Depending on the procedures within your individual CASA program, these files may be available to you through program staff, or you may need to submit a request to DCP&P to review (and, to the extent necessary, copy) these files.

After you have an initial meeting with your Case Supervisor or other designated staff person to collect/review the file for information, you should begin to schedule information gathering visits. When scheduling your visits, you should call first to explain the CASA role and the purpose of the proposed visit – this will promote good will and demonstrate respect for the other person's role going into the visit. This also allows the other person to make the necessary preparations (i.e., obtain clearance, pull files, and set aside time for the visit). A copy of the Order of Appointment should be forwarded prior to the visit to ensure cooperation.

It is critical that you review all available medical files in order to get a candid snapshot of the child's healthcare history and ensure that any health-related issues are identified and addressed.

As you begin gathering information, you should complete the *Advocate Questionnaire for Medical Information*, which contains questions regarding the basic, minimum information needed to initiate any healthcare advocacy. The information obtained and documented on this *Questionnaire* can then be used as the jumping off point in compiling a complete healthcare history for the child.

If the DCP&P file and HCCM Record do not contain a complete record (or all of the healthcare information that you feel is needed), then you can request further information from a variety of sources. Utilizing the steps outlined in the *CASA Health Information Gathering Guide*, you can seek information from the sources outlined on the page entitled *Healthcare Information Sources*. Additionally, the following list, while not all inclusive, is an excellent starting point in trying to create a healthcare file:

- Local DCP&P office (may or may not contain complete medical history)
- School nurse (may have immunization records, hospital/Primary Care Provider healthcare records)
- Child's Primary Care Provider (may be complete if the child has been seen regularly)
- Biological Parents/Family Members (may or may not possess complete healthcare records)
- Foster Parents (may or may not have complete records)

As you begin compiling full medical information, be sure that the information is kept as part of your CASA program's child and case information database, and as part of any hard copies, as applicable.

Ensuring Appropriate Healthcare

Chapters 2 through 5 of this manual should provide you with a significant amount of information and a variety of "Points of Advocacy" that can be utilized to help ensure that the healthcare needs of your assigned child are being met and that the child is receiving the appropriate healthcare. Again, the primary goal of CASA Medical Advocacy is to ensure that the child receives both regular well-care as well as any other necessary healthcare services while they are in placement. It is NOT your role as a CASA volunteer to diagnose a child or recommend specific treatments. Rather, as the CASA volunteer, you should be working closely with the child's DCP&P caseworker and CHU nurse to ensure that timely and appropriate healthcare is being provided and that the child's medical and mental health needs are being met.

Depending on your individual child's medical issues, there may come a time when non-routine medical interventions are necessary (including but not limited to surgery or special testing). DCF policy states that, unless parental rights have been terminated, any such non-routine medical interventions would require parental consent. In the event that parents are not available or able to consent, DCP&P would seek Court intervention to allow the DCP&P Local Office Manager (or his/her designee) to provide the needed consents. Additionally, if a youth is 18 or older, it is up to them to provide consent for both routine and non-routine care. It is important to remember the critical role that you as the CASA volunteer can play in ensuring that the appropriate consents have been provided for non-routine medical interventions.

As a CASA volunteer, you are in a unique position to facilitate communication regarding the consents needed and to ensure that they are provided. There are many steps to be taken and signatures needed along the way when a child needs surgery or other non-routine care – you can facilitate communication to ensure that parents, caregivers, and DCP&P are aware of what is needed and that steps have been taken to ensure that the needed items are in place. In addition, you are able to be present to provide support to the child and even the caregivers during any non-routine medical intervention – this can mean so much to a child.

Providing the Court with Timely, Objective Information

As the CASA volunteer, you should provide the Court with timely, objective, and unbiased information based upon the information gathered. The vehicle for this information is the CASA Court Report. The CASA Court Report should include updates on the child's health, including information on the provision of well-care as well as information on any specific medical or mental health needs and whether they are being addressed. If necessary, you should make recommendations for the child to receive any needed assessments and/or services, the status of any special interventions or services, and the child's ongoing well-care. However, such recommendations should only be made following unsuccessful advocacy to DCP&P for those assessments and services. In the event that you have been unable to obtain information, that fact, along with information about the efforts made to date, should be included in the Court Report as well. Some *Sample CASA Court Reports* are provided as an example of the various pieces of information and recommendations that might be made.

Points of Advocacy for CASA

- CASA volunteers are the front-line information gatherers and play a key role in ensuring that the child's medical file is as up to date and complete as possible. The volunteer should utilize the various manual resources to

ensure that they are gathering all available information and documenting the information obtained.

- CASA volunteers have a unique relationship with the Court such that, if advocacy efforts with DCP&P do not succeed in getting a child's healthcare needs met, the CASA volunteer can make a fact-based recommendation in their Court Report in order to get the child's healthcare needs met.
- Remember, it is NOT the role of the CASA volunteer to diagnose a child or recommend specific treatments. Rather, the volunteer should be working closely with the child's DCP&P caseworker to ensure that timely and appropriate healthcare is being provided and that the child's medical and mental health needs are being met.
- In the event that a child requires non-routine medical interventions, CASA can play a critical role in ensuring that all required forms and consents are in place so that the intervention can proceed without delay. In addition, the CASA volunteer's presence during any non-routine medical intervention lends a great deal of support to the child, the parents, and the caregivers.

Manual Documents:

- Advocate Questionnaire for Medical Information
- CASA Health Information Gathering Guide with Healthcare Information Sources
- Sample Court Reports

Note to Case Supervisors:

CASA Manager or any other data collection software being utilized by your CASA program should always be updated with information regarding the child's healthcare.

For those CASA programs utilizing CASA Manager, these updates are to be made in the "Health" tab of the Family/Child Information section of CASA Manager. There are four (4) different screens where information can be entered:

1. Immunizations/Meds – here, you can list the child's doctor(s), insurance, medications, and immunizations with dates
2. Health Exam – here you can collect all information regarding any CME that the child has undergone initially and on-going, including information regarding the findings of those assessments.
3. Plan of Care – here you can input and track any and all follow-up care that the child requires as a result of the Child Medical Exam.
4. Ongoing Care – this area allows you to input and track all ongoing care that the child is receiving, whether it is well-care pursuant to EPSDT guidelines or other healthcare that the child is receiving on an ongoing basis.

CASA programs can also use CASA Manager to track the medical/mental health services for which the program has advocated by going to the "Services" tab of the Family/Child Information section of CASA Manager. By keeping these screens current, CASA can maintain a record of the child's healthcare needs and whether those needs are being met.

Advocate Questionnaire for Medical Information

1. Who is the child's primary healthcare provider (or the child's medical home)? (A pediatrician, nurse practitioner, or family practice doctor)	Name_____ Address: _____ _____ Telephone # _____
2. When was the last time the child saw the primary healthcare provider (what for)?	Date _____ (Provide name, address and phone if different from above) Reason:
3. How often does the child go to the healthcare provider (in a year)?	
4. Any medical conditions or diagnosis the child is being treated for (both past & present) Any medications?	Conditions/Diagnosis: Medications:
5. Has the child had their • Pre-Placement Assessment (PPA), • Comprehensive Medical Exam (CME) or Comprehensive Health Evaluation for Children (CHEC),	PPA (within 24 hours of removal) Date:_____ CME/CHEC (within 30 days of removal) Date: _____

• Mental Health Screening, • Mental Health Assessment? If so, when?	Mental Health Screening (within 30 days of removal, and then every 180 days thereafter) Dates: _____ Mental Health Assessment Date: _____

CASA Health Information Gathering Guide

Resources and steps to gathering healthcare information

Step 1:	Request review of the child's DCP&P case file and blue Health Care Case Management (HCCM) file and identify the child's Primary Care Physician (PCP) or Medical Home and their contact information.
Sources:	*DCP&P caseworker as well as Resource parent and school nurse*
Step 2:	Discuss the child's healthcare status with the child's resource parent. Determine any concerns, known conditions, healthcare professionals that are involved and any upcoming or recent appointments.
Step 3:	Determine if a Comprehensive Medical Exam (CME) was performed or is scheduled – obtain copy of the report as well as any Pre-Placement Assessment (PPA) report.
Sources:	*See #8 on chart below*
Step 4:	Review DCP&P case file for any medical information, reports, etc. as well as the child's blue HCCM file, and check with the caseworker about any known healthcare issues or appointments.
Step 5:	Complete Section I of Health Information Checklist.
Sources:	*DCP&P file/worker, HCCM file, resource parent, other sources listed in chart on the following page.*
Step 6:	Request child's PCP provide the information for Section II on the Health Information Checklist. *If there is a fee involved or other problem, ask the DCP&P Case Worker to request the information from the doctor.*
Step 7:	Complete Section II of Health Information Checklist – if not completed by the PCP.
Sources:	*See chart on the following page.*
Step 8:	Provide all healthcare information obtained to the CASA Case Supervisor.

Healthcare Information Sources

Information Needed	*Sources to Obtain Information*	*Additional Comments*
1. Immunizations	• School Nurse • Child's primary doctor/Pediatrician • Foster/Resource parent(s) • Focus Report** • NJIIS Report** • DCP&P Case File • DCP&P Case Worker	** These reports can only be produced by the division, when requested by CASA or its Advocates they must provide a copy. Please have your Court Appointment Order with you to show to the different agencies if needed.
2. Specialty Health Care (ex. Neurology, Orthopedic, Gastroenterology, etc.)	• Primary Care Doctors/ Pediatrician • Previous Primary Care Doctors/Pediatrician	Please have your Court Appointment Order with you to show to the different agencies if needed.
3. Physical Health Care (ex. Neurology, Orthopedic, Gastroenterology, etc.)	• Primary Care Doctors/ Pediatrician • Previous Primary Care Doctors/Pediatrician	This information may also be found in the DCP&P Case File
4. Dental Care	• Child's Dentist • Foster/Resource parent(s)	This information may also be found in the DCP&P Case File
5. Mental Health Services	• Child's primary doctor/Pediatrician • Foster/Resource parent(s) • DCP&P Case File • DCP&P Case Worker • The child's known mental health provider	
6. Medications/Special medical Equipment	• School nurse • Child's primary doctor/Pediatrician • Foster/Resource parent • Specialist MD • Focus Report**	Examples of special equip.: nebulizer, wheelchair, hearing aid, etc.
7. Chronic Health Conditions	• Child's primary doctor/Pediatrician • Foster/Resource parent(s) • DCP&P Case File • DCP&P Case Worker • School Nurse	Examples of special equip.: nebulizer, wheelchair, hearing aid, etc.
8. CHEC Exam Report CHEC Preliminary Report or Comprehensive Medical Exam (CME) report	• DCP&P Case File • Foster/Resource Parent(s) • Pediatrician/Family Dr or CME provider	Due to a shortage of CHEC centers and Dr.'s, in lieu of a CHEC exam, children may receive a CME or well child exam by their PCP. Request copies of both the preliminary and final reports for these exams.

Notes:

1. When requesting information or visiting outside agencies, please set up appointments. This includes visits with the Division (DCP&P).
2. Always provide a copy of your Court appointment order.

CASA REPORT TO THE COURT

CASE NAME:	**Emma Barnes**	**CASE NO:**	**FC-14-32-11**
COURT DATE:	**January 5, 2012**	**REPORT DATE:**	**December 28, 2011**
CASA VOLUNTEER:	**Janet Collins**	**DATE OF APPOINTMENT:**	**August 12, 2010**

BACKGROUND SUMMARY:

On August 4, 2010 Emma Barnes was admitted to Morristown Memorial Hospital with severe injuries including fractures in her arm, ribs, legs, and internal bleeding in her brain. It was determined at that time that the child had suffered historical injuries which were in various stages of healing, leading the hospital staff to believe that she had been the victim of ongoing physical abuse. The birth mother could not give a plausible explanation for the child's injuries and she was incarcerated for child endangerment and aggravated assault. Both Emma and her half-brother, Zachary, were placed in DCP&P custody and different foster homes. An older daughter had previously been removed from her custody and is living with the maternal grandmother in Pennsylvania.

CONTACTS: (Since 10/6/11)	**Telephone**	**In-Person**	**Written**
H E.	1		
Foster Parents	16	4	2
AK, DCP&P Caseworker	4	2	1
JW, DCP&P Supervisor	2	2	
DCP&P Team including Nurse		1	1
CASA Supervisor	4	2	5
CASAs involved in case	16	2	10
MJ, Early Intervention Coordinator	1		3

CURRENT STATUS:

Placement and Adjustment:

Emma has lived with her current foster family for one year. Also living in the home are two young children who were previously adopted through foster care and another 4-year old foster child. The foster mother is a nurse and has been very active in securing the treatments required for the child. The foster parents are providing a warm and caring home and Emma appears to be thriving in the environment. Foster parents and therapist report they are thrilled with the progress Emma has made.

Medical:

Emma continues to have regularly scheduled checkups with her pediatrician. Her last visit was for her 18-month checkup and, according to the DCP&P medical file, all immunizations were up to date. Her next scheduled appointment is for February. She is also seen on regular intervals by Dr. A Carlisle, an ophthalmologist, who feels that her left eye may be stronger than her right causing her to lean her head to enable her to see through the stronger eye. She will not require another eye doctor appointment for one year, but she is seen once a month by a vision therapist from St. Joseph's Hospital. She does have regularly scheduled appointments with a pediatric neurologist, neurosurgeon and rehab physician. She was recently taken off Phenobarbital for

seizures and her only current medications are multiple vitamins. Her last dental appointment with Dr. R Norman was two weeks ago and there were no problems. She is currently being treated in the home by a physical therapist once a week and an occupational therapist twice a week. In January both therapists will come twice a week. All doctors and therapists are very pleased with her progress.

Psychological:
The child always appears quite content when seen by this CASA.

Educational:
Emma is seen by a special education teacher through Early Intervention each week. In a report from the P. G. Chambers School dated November 9, 2011 her emotional and social development fell within the 12-18 month range on the Brigance Inventory of Early Development.

Visitation:
H.E., the birth mother, has been denied visitation. Mr. RC, the birth father, has no interest in visiting and wishes to surrender his parental rights. Mr. DC, paternal grandfather, does visit regularly through DCP&P and frequently has other relatives accompany him on these visits.

Parental Compliance and Progress:
The birth mother has not gained stable housing, feels a job would be "too stressful" and has not attended counseling as ordered. The birth father is currently living in Pennsylvania and, as stated previously, has no interest in involvement in the child's life.

RECOMMENDATIONS:
1) That the child remains in the current foster home.

2) That the child continues to receive the medical care she is currently receiving.

3) That the child should be evaluated as appropriate.

4) That visitation remains suspended until further order of the Court.

Respectfully submitted,

Janet Collins
Court Appointed Special Advocate

Jack Fraebel
CASA Case Supervisor
973-998-7590 Ext 12

BURLINGTON COUNTY COURTHOUSE
Docket No: [redacted]
Report Date: 10/15/2015

COURT APPOINTED SPECIAL ADVOCATE REPORT

Client Name: [redacted]

Date of Birth: 1/18/2013

Type of Hearing and Date: Summary Hearing, 10/23/2015

Law Guardian: Sharon Piccioni

DAG: Elizabeth Wallace

Attorney: Jeffrey Gladden, Esq. for mother

CASA Volunteer: Wayne Grand

Report Prepared by: Wayne Grand

THIS REPORT IS OF A CONFIDENTIAL NATURE FOR THE BENEFIT OF THE COURT AND MAY BE DISTRIBUTED ONLY TO PARTIES OF THE PROCEEDINGS.

CONTACTS:

CASA of Burlington County 100 High Street, Suite 301 Mount Holly, NJ 08060
Tel: 609-265-2222 Fax: 609-265-2220 staff@casamercer.org
Member of the National Court Appointed Special Advocate Association

Contact Name	Relationship to Child	Dates of Contact	Type of Contact (Telephone, In-Person, Left Message, Written)
[redacted]	Maternal Aunt, Resource Parent	9/11; 10/9	In-Person
Dawn Ramosl	Maple Shade Child Study	10/2/2015	In-Person

PERMANENCY STATUS:

Date of Abuse and Neglect Filing: 3/8/2013

Date of Termination of Parental Rights: 9/9/2015

Permanent Plan Adopted On: September 9, 2015

Current Permanency Goal: Adoption by relative

Date of Last Hearing: 9/9/2015

EARLY INTERVENTION SERVICES (EIS) STATUS :

Has an EIS evaluation been completed? (*applies to children who entered care between ages 0-3*) Yes

Date Completed: Unknown

If not completed, date scheduled: N/A

CASE HISTORY

Jane was placed with her maternal aunt due to concerns regarding domestic violence (verbal and physical), substance abuse (alcohol) by her natural father, and mental health issues. Additionally, the parents have had difficulties in meeting the child's medical needs despite two years of instruction.

On September 9, 2015, Mother did an identified surrender of parental rights to Jane's maternal aunt. Father, Mr. S, had surrendered his parental rights on August 3, 2015.

SUMMARY OF CHILD'S SITUATION:

Placement:

Jane continues to live with her maternal aunt who is planning to adopt her. Jane has developmental and neurological difficulties and is provided with Early Intervention Services at her resource home, where she receives physical, occupational, and behavioral therapy. The physical therapist is working with Jane on walking skills and recently Jane has been successful in walking on her own. She is working on being able to step over objects and will then begin to walk steps. The occupational therapist is concentrating on developing grasping skills as well as learning beginning

sounds for speech. The behavioral therapist is working on making choices, engaging in activities that Jane does not like, and improving her attention.

Visitation

Now that Ms. F and Mr. S have surrendered their parental rights, no formal visitations have been scheduled.

School

Jane is two and a half years old and will be eligible for the Pre-School Handicapped Program through the Maple Shade School system once she turns three in January. In September DCP&P was able to provide Maple Shade Child Study with doctor summaries regarding her medical conditions. This CASA attended a meeting with Child Study Team on 10/2/2015 to discuss Jane's needs and for the maternal aunt, Ms. D, to sign the Child Study Team evaluation. Ms. D provided Jane's medical history as well as information regarding services provided to Jane through Early Intervention. Ms. D addressed the needs that are not being provided to include speech and feeding therapies. Because of Jane's need for many therapies Ms. D expressed the need for a full day program, which is unavailable in the Maple Shade Pre-School program. As testing has not been performed, the Child Study Team could not conclusively say that a full day program out of district would be provided, but indicated that this could be the case. A discussion of various programs did occur with Ms. D indicating that she did not want Jane sent to Burlington County Special Services School District, but was supportive of LARC, which is a non-profit special education school. St. John of God was also mentioned by Ms. D.

Jane's evaluations by the Child Study Team will include Social, Speech, Occupational and Physical Therapy. Ms. D will seek an updated Neurological exam from Jane's doctor. Ms. D would like behavior therapy to continue at the rate of two hours a week. This request was shelved for later discussion. It was also discussed whether Jane's nurses could accompany her to school and provide nursing services there. The Child Study Team will look into this request. Ms. D also mentioned the need for a specialized chair for the bus. The Child Study Team requested that Ms. D explore this further with Early Intervention, but did provide some information regarding one type of device called a Kid Cart.

Mental Health

N/A

Medical

Comprehensive Medical Exam Status:

Has a comprehensive medical exam taken place? (*applies to children who removed from their home after 11/15/04*) Yes

If so, which type?
__x__ CHEC (Comprehensive Health Evaluation for Children)
____ CME (Comprehensive Medical Exam) at a designated site.

__x__ Comprehensive exam by pediatrician

Date Completed: Jane has an extensive medical history with numerous ongoing medical conditions which include: Ventricular Septal Defect, Microcephalus, Gastroesophageal Reflux Disease or GERD and recently Epilepsy. She is unable to tolerate food and is on an 18 hour regimen of PediaSure through a gastrostomy tube, which is affixed to Jane through a MIC-KEY button. Other medical diagnoses include: Hypotonia, Ataxia, Hip Laxity, and Paraspinal Dimples. Jane also suffers from asthma and takes Pulmicort, uses an inhaler and a nebulizer. Jane recently received an EEG, which found her to have irregularities in the back of her head according to the foster mother. A video test was performed on August 27, 2015 to get more information regarding possible epilepsy and it was found that Jane was high risk for seizures. Additionally a ten-day night study was done, with no seizures observed. However, Jane had her first seizure in September. She has been prescribed Levetiracda for the seizures, but the resource parent is unhappy with the side effects (behavioral problems) and thus has not given her the medication as of yet.

If not completed, date scheduled: N/A

Has a mental health and behavioral exam been recommended by the physician who conducted the medical exam?

Jane receives Behavioral Therapy twice a week through Early Intervention where she is working on making choices, increasing her attention to tasks, and complying with completing activities that she does not care for. There has been an increase in biting and pulling hair.

Date Completed: 5/9/2015

If not completed, date scheduled:
N/A

Dates of Medical Care:

Date of last appointment with pediatrician: Unknown

Date of last dental appointment: N/A

SUMMARY OF PARENTS SITUATION

Biological Mother

Ms. F did an Identified Surrender of her parental rights to Ms. D on September 9, 2015.

Biological Father

Mr. S surrendered his parental rights on August 3, 2015.

RECOMMENDATIONS:

Based on the knowledge gained during my independent investigation of this case, I recommend that:

1. Jane remain in the current resource home with Ms. D until adoption is finalized.
2. Ms. D obtains further information regarding a chair to lift Jane into the bus from Early Intervention so that it is available for her by January.
3. Speech and Feeding Therapies to be added to Jane's Pre-School Handicap Program.

Respectfully Submitted,

Wayne Grand
CASA Volunteer

Ines Ramirez
Case Supervisor

CASA REPORT TO THE COURT

CASE NAME: Carol Angelo
DOB: 6/11/10

CASE NO: FN-14-180-10

COURT DATE: 12/5/2013

REPORT DATE: 12/3/13

CASA VOLUNTEER: Sally Linder

DATE OF APPOINTMENT: 5/12 /2012

BACKGROUND SUMMARY: DCPP placed Carol Angelo in a resource home 5/5/2011 after it was determined in Family Court that her mother needed a level of care that could not be found in a "mommy and me" placement.

Carol was born with a cleft lip and palate; lip/soft tissue repair has been done and hard palate repair with minor lip revision was done 7/19/11. A small fistula remains.

CONTACTS since 5/2/2013:	Telephone	In-Person	Written
Carol Angelo		4	
Mother		2	18txts
Resource Parents		2	25 txts

CURRENT STATUS: This CASA last visited Carol in her resource home.
She is active, engaged and happy; climbing into laps, book in hand asking to be read a story and playing with her older "brother".

PLACEMENT & ADJUSTMENT: Carol is affectionate, talkative, playful and very happy in her resource home.

MEDICAL: Carol's comprehensive medical exam was done May 23, 2011. Her first cleft surgery was in September 2010 and the second was September 2011. She is being followed at St. Barnabas Craniofacial Center. Approximately 5 future surgeries will be required but none are currently scheduled. She saw the Craniofacial Team again December 6, 2012. The report indicates that her hearing is within normal limits and her speech has reached age appropriate levels. The team will see her for another full assessment when she reaches 3 years old.

She sees her pediatrician, Dr. Patricia Griffiths, for routine care and is current with vaccinations as of December, 2013.

Carol has been released from speech therapy, supplied by Early Intervention Services.

PSYCHOLOGICAL: Carol's evaluation at St. Barnabas in September 2011 identified no need for psychological intervention.

EDUCATIONAL: Carol continues to do very well at day care according to her resource parents.

VISITATION: Carol sees mom monthly for supervised visits. Mom was not able to coordinate transportation for the October visit but did attend the November visit after which she expressed to this CASA that the visit was "awesome" and that she "loves Carol to death" and misses her terribly.

It is this CASA's understanding that Carol has not seen her father since the last report.

PARENTAL COMPLIANCE & PROGRESS:
Mother has moved out of her father's home in Morristown and is now residing with "random people" and her boyfriend in Montague. Mother is not in school, therapy or drug treatment program. It is difficult for this CASA to ascertain the stability of the mother's outlook, housing and employment. In September she texted about bad dreams and thoughts. She texted in October that she was not feeling better. In November the mother texted that she is "short on a bill" and requested cash help.

RECOMMENDATIONS:
1. That Carol remain in her current resource home and be adopted.
2. That Carol continues care at St. Barnabas Craniofacial Center
3. That drug testing continues for Mother at every visit.

Respectfully submitted,

Sally Linder
CASA Volunteer

Jack Fraebel
CASA Case Supervisor
973 998-7590 Ext.12

APPENDIX A: GLOSSARY OF TERMS, ACRONYMS & ABBREVIATIONS

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
APN	Advanced Practice Nurse
BP	Blood Pressure
CASA	Court Appointed Special Advocate
CBC	Complete Blood Count
CDC	Centers for Disease Control
CHEC	Comprehensive Health Evaluation for Children – a Comprehensive Medical Evaluation (CME) completed by a CME provider at a Regional Diagnostic and Treatment Center (RDTC). A CHEC requires a three part examination – medical, mental health and neurodevelopmental.
CHP	Child Health Plan
CHU	Child Health Unit
CME	Comprehensive Medical Examination – a physical examination and mental health screening done within 30 days of a child entering placement. The CME can be completed by a contracted provider or the child's primary care physician.
CNC	Clinical Nurse Coordinator
CSII	Continuous Subcutaneous Insulin Infusion
DCF	Department of Children and Families
DCP&P	Division of Child Protection and Permanency (formerly DYFS)
DO	District Office (of DCP&P)
Dta P	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine
EIP	Early Intervention Program
EPSDT	Early and Periodic Screening, Diagnosis and Treatment – comprehensive, preventive health program involving regular well-child visits designed for early identification of health needs and routine screening for both physical and mental health needs.
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
GP	General Practitioner
HBC	Health Benefits Coordinator
HBID	Health Benefits Identification
HCCM	Health Care Case Management
Health Passport	A multi-page form containing child health information to the extent available and known to DCP&P; completed by the CHU Nurse and updated regularly. It should follow the child through their entire time in placement and be shared with child and caregivers upon exiting care.
Hep B	Hepatitis B Vaccine
HIB	Haemophilus Influenzae type B vaccine

HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organizations
HPV	Human Papillomavirus
IPV	Inactivated Polio Vaccine
LMP	Last Menstrual Period
LO	Local Office (of DCP&P)
MACC	Medical Assistance Customer Centers
MD	Medical Doctor
Medical Home	A consistent primary care physician/pediatrician for the child who will provide for the child's basic health needs while helping the family access, coordinate, and understand specialty care and arrange for such specialty care, if necessary, usually via referral.
Mental Health Assessment	An assessment that is completed by a mental health professional in the event that there are concerns about a child's mental health status. The assessment may or may not follow a Mental Health Screening.
Mental Health Screening	A screening that takes place within the first 30 days a child is in placement, the purpose of which is to identify children with a suspected mental health need and refer those children for a full Mental Health Assessment. See Manual pages 2-4 and 2-5 for further explanation.
MMC	Medicaid Managed Care
MMR	Measles, Mumps, and Rubella Vaccine
NJIIS	New Jersey Immunization Information System
NJS	New Jersey Spirit
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
ODD	Oppositional Defiant Disorder
OOH	Out-of-Home Placement
PCP	Primary Care Provider
PDD	Pervasive Developmental Disorder
PMD	Primary Medical Doctor
PPA	Pre-Placement Assessment – an assessment that must be completed within 24 hours of placement, the purpose of which is to evaluate the child's health status and identify any immediate health needs of the child.
PSC	Pediatric System Checklist – used in NJ for child Mental Health Screening
PTSD	Post-Traumatic Stress Disorder
RAD	Reactive Attachment Disorder
RDTC	Regional Diagnostic Treatment Center
RP	Resource Parent
SCHS	Special Child Health Services
SPRU	Special Response Unit
TB/PPD	Tuberculosis Purified Protein Derivative (TB skin test)
Td	Tetanus and Diphtheria Toxoids
VAERS	Vaccine Adverse Event Reporting System
VFC	Vaccines for Children Program

Selections from Amarillo Case Study

Adopted from National CASA Pre-Service Training Manual, Flex-Learning Edition

DCPP Case File

Children's Names	Current Age	Current Placement
Maria Amarillo	16 years	Foster Home: Stanley and Karen Becker
Joanna Amarillo	6 years	Foster Home: Stanley and Karen Becker
Graciela Amarillo	4 years	Foster Home: Stanley and Karen Becker

Case History

A neighbor called police as a result of "loud shouting" in the home of Myrian and Jose Amarillo. Police found three children on the scene (Maria, Joanna and Graciela) and removed the children from the home based upon evidence at the scene including parents too inebriated to provide a safe home for their children and mother's bruises and bleeding as a result of a fight between her and her husband. DCPP was notified and the children were placed together in emergency foster care.

Following an emergency hearing, the Amarillo children were placed in three separate placements. Joanna and Graciela were each placed in separate foster homes, and Maria was placed in a group home for girls. Two months later, Joanna was moved in with Graciela. Throughout the next year, Maria was placed in various group homes and foster homes, often running away from them. On one occasion, Maria was found when County General Hospital called DCPP to report Maria Amarillo had been admitted after a 911 call from the home of a friend. Maria was admitted following a severe asthma attack.

About 10 months after the children were removed from home, Joanna and Graciela were moved to their current foster home, with Stanley and Karen Becker, because the prior home was expecting a baby of their own and no longer wanted to foster. Stanley and Karen Becker immediately indicated their interest in fostering Maria, and 4 months later the decision was made to move Maria into their home.

According to Maria, her parents moved her from El Salvador to the United States when she was "little," just after her brother died of Type 1 Diabetes. Maria stated "They didn't want the same thing to happen to me."

Medical History for Maria Amarillo

Maria indicated a history of asthma dating back to age 7, and of attempting to control her asthma through natural and behavioral methods. She is reluctant to accept medication for this. Maria's primary care physician has referred her to a Pulmonary Specialist for her Asthma. According to Karen Becker, the physician to whom Maria was referred does not accept Medicaid.

Maria also has Type 1 Diabetes. She has had regular annual screenings since her removal from her parents, and it has been determined that her glucose and insulin levels have been well regulated.

Approximately one year ago, Maria began taking Ortho-Cept (28) Oral, birth control. According to Maria, "I've had a lot of problems with my period and my doctor said these would help. But they make me break out. And I feel fatter. I might see if I can stop taking them."

Maria is current on her well-child checks, dental check-ups and immunizations.

Medical History for Joanna Amarillo (not included in National CASA materials)

Joanna has been diagnosed ADHD and is currently taking Vyvanse to help her focus in school.

Joanna's Health Passport shows that she is current on well-child checks and immunizations. At her last dental exam, 4 months ago, she was diagnosed with 3 cavities that have not been filled. The Beckers indicated this is because the dentist said Joanna's insurance will not cover the fillings. Joanna does not have any ongoing medical conditions.

The Becker's have expressed a concern that Joanna may have an unaddressed mental health problem. Increasingly, Joanna is having "temper tantrums" that have included breaking glass such as picture frames and dishes, rolling on the floor, and threatening to kill Graciela.

Joanna's growth chart is attached.

Medical History for Graciela Amarillo (not included in National CASA materials)

Graciela's Health Passport indicates that she is six months late for her 4 year Well-Child visit or Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program visit to a pediatrician.

Graciela has a severe, possibly life-threatening allergy to Penicillin. She does not have any ongoing medical conditions and her DCP&P record states that she is current on immunizations and dental check-ups.

Graciela's immunization record is attached.

2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

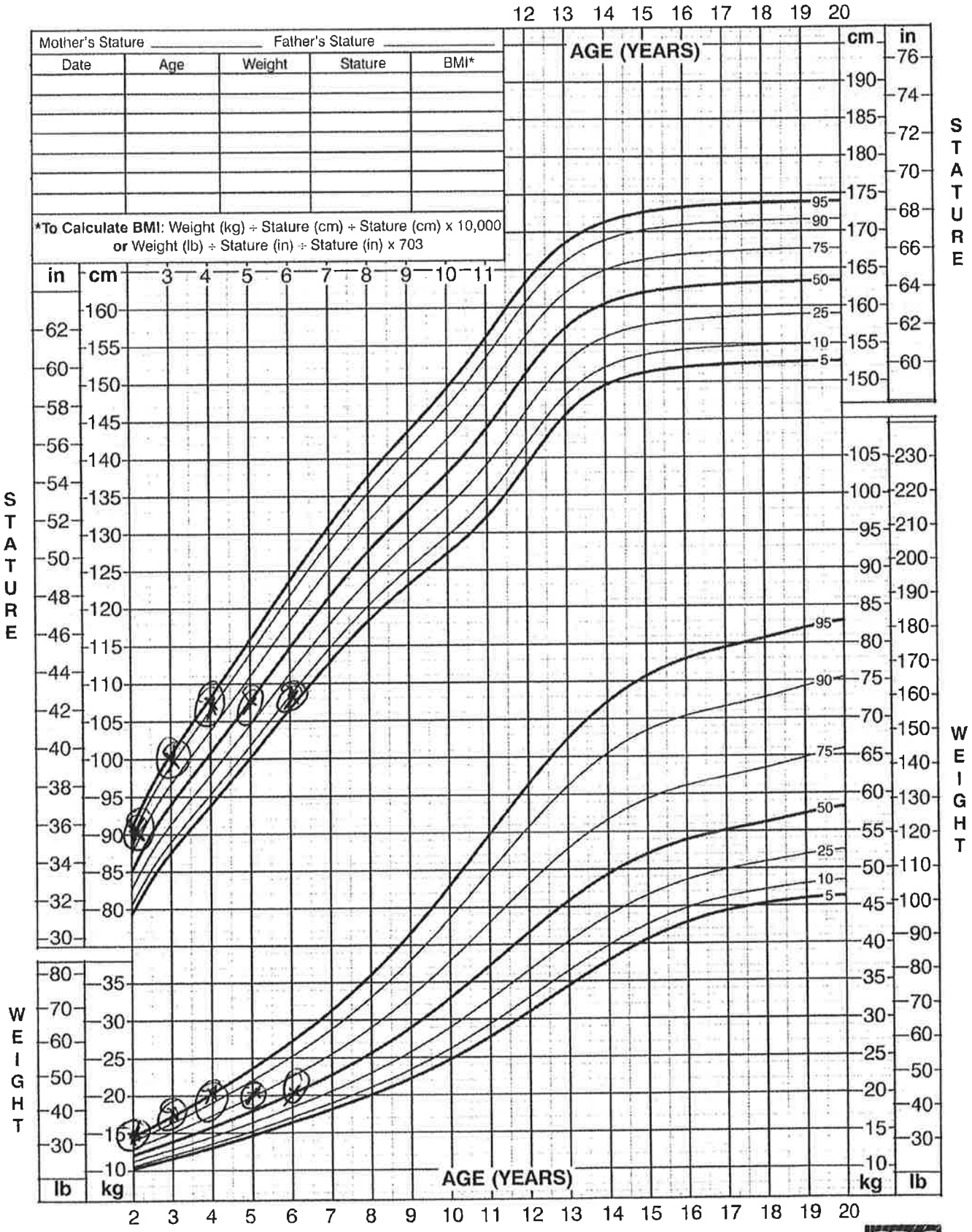
NAME Joanna Amarillo

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC

SAFER • HEALTHIER • PEOPLE

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI) Amarillo, Graciela	DATE OF BIRTH (Mo./Day/Yr.) 5/5/2012	SEX ☐ M ☒ F
NAME OF PARENT/GUARDIAN Myrian Amarillo	TELEPHONE NUMBER(S)	
ADDRESS 123 Anyplace St., Anytown, NJ		
ADDRESS	IMMUNIZATION REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING (Not Required) TEST DATE	LEAD SCREENING (Not Required) RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (if Td or DT[1] Indicate in corner box)	7/5/12	9/7/12	11/9/12	9/9/13			
POLIO-INACTIVATED POLIO VACCINE (IPV) (if oral vaccine, indicate OPV in corner box)	7/5/12	9/7/12	11/8/12				
MEASLES, MUMPS, RUBELLA (MMR)	5/9/13						
HAEMOPHILUS B (HIB) [2]	7/5/12	9/7/12	11/8/12				
HEPATITIS B [3]	5/5/12	7/5/12	11/8/12				
VARICELLA [4]	5/9/13						
PNEUMOCOCCAL CONJUGATE [2]	7/5/12	9/7/12	11/8/12	5/9/13			
INFLUENZA [6]							
OTHER, SPECIFY:							

[5] Document below single antigen vaccine receipt, serology titers, or Varicella disease history

	DATE:	TITER:
Hepatitis B		
Varicella		
Measles		
Mumps		
Rubella		

☐ Provisional Admission Attached - Date Granted:_____ ☐ Medical Exemption Attached ☐ Religious Exemption Attached

IMM-8
OCT 08

(1) REQUIRES MEDICAL EXEMPTION
(2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
(3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04
(4) REQUIRED FOR DAY/CHILD CARE ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04
(5) MMR single antigen receipt requries MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)