

Ohio Department of Job and Family Services  
**CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE**

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

<p>This form shall be completed when a child has a condition that requires one of the following:</p> <ul style="list-style-type: none"><li>• Monitoring the child for symptoms which require staff to take action</li><li>• Ongoing administration of medication or medical foods</li><li>• Procedures which require staff training</li><li>• Avoiding specific food(s), environmental conditions or activities</li><li>• School-age child to carry and administer their own emergency medication</li></ul> <p>If the medication or medical food is documented on this form, then a JFS 01217 is not required.</p>
Child's Name
Special Health Condition
Does this health condition require medication or medical food? <input type="checkbox"/> Yes (If Yes, complete Part II) <input type="checkbox"/> No
A. What are the signs, symptoms, or situations which require staff to take action?
B. What are the activities, foods, environmental conditions, etc. to avoid? <input type="checkbox"/> Not applicable
C. What are the training instructions for the procedures staff have to follow? <i>(include all steps to care for the child/perform the medical procedure)</i>

**Part II: Conditions Requiring Medication or Medical Food**

**Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

**(If no medications or medical foods are required for the condition, skip Part II).**

**If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.**

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight <i>(if needed to determine dosage)</i>
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Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature
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**Part III: Administration of Medication or Medical Food Training Authorization**  
**Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)**

**Part III must be completed**

Child's Name \_\_\_\_\_

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? (Check all that apply)

Medication       Supplies       Assistance       N/A

<b>Parent Provided Training AND grants permission to perform the procedure</b>	<b>Complete Only One Section</b>	<b>Certified Professional Training AND parent grants permission to perform the procedure</b>	
<i>My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>	
Parent Signature _____		Certified Professional's Name (please print) _____	
Date of Signature _____		Certified Professional's Signature _____	
		Date of Signature _____	Phone Number _____
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>	
		Parent Signature _____	
	Date of Signature _____		

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name _____	Signature _____	Date _____
Printed Name _____	Signature _____	Date _____
Printed Name _____	Signature _____	Date _____
Printed Name _____	Signature _____	Date _____
Printed Name _____	Signature _____	Date _____
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>	Administrator/Provider Signature _____	Date of Signature _____

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials _____	Date of Review _____	Administrator/Designee Initials _____	Date of Review _____
Parent/Guardian Initials _____	Date of Review _____	Administrator/Designee Initials _____	Date of Review _____
Parent/Guardian Initials _____	Date of Review _____	Administrator/Designee Initials _____	Date of Review _____
Parent/Guardian Initials _____	Date of Review _____	Administrator/Designee Initials _____	Date of Review _____
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