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.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods.
- Administering procedures which require staff to be trained on those procedures
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication is documented on this form, then a JFS 01217 is not required.

Child's Name	Date of Birth

Special Health Condition

Does the condition require medication?

☐ Yes

☐ No

☐ **Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.**

1. What are the symptoms to watch for?

2. When should the medication or medical food be administered?

3. What are the instructions for administration?

4. What triggers the need for medication or medical foods?

5. What are the expected results of the medication or medical foods?

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

7. What are the activities, foods, environmental conditions to avoid? ☐ Not applicable

Training instructions *(include all steps to administer the medication or perform the medical procedure)*

☐ Included on attached physician's instructions

If expected result of medication or medical food does not occur:

☐ Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

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

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

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

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
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The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication