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 8 are included on a separate sheet with physician's instructions.**

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

2. What are the instructions for administration?

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

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

5. What if expected result does not occur? List the directions to contact the parent or medical personnel.

6. What are the symptoms to watch for?

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

8. 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
☐ Only action is to contact parent or medical personnel

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

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

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Child's Name *(print or type)*	Date of Birth

***To be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):**

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below)*:

√ The above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below if the immunization was medically contraindicated or not medically appropriate for the child's age).

Varicella [ ]; TDaP [ ]; Hib [ ]; Hep A [ ]; Hep B [ ]; Influenza [ ]; MMR [ ]; PCV [ ]; Polio [ ]; Rotavirus [ ]

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) may accompany this form.

Optional: Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other:	
Measurements:		**Notes:**	
Height			
Weight			
BMI			

Signature of Examining Health Care Practitioner*	Date of Examination
Name of Examining Health Care Practitioner*	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code for reasons of conscience including religious convictions. Please note disease below and sign.

Varicella [ ]; TDaP [ ]; Hib [ ]; Hep A [ ]; Hep B [ ]; Influenza [ ]; MMR [ ]; PCV [ ]; Polio [ ]; Rotavirus [ ]

Signature of Parent	Date of Signature