

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

| | | | |
|---|--------------|---|---|
| Child's Name | | Date of Birth | |
| Special Health Conditions | | | |
| Symptoms to watch for and emergency action to be taken if the following symptoms occur | | | |
| Activities/foods/environmental conditions to avoid, if applicable | | | |
| Medical procedures to be followed and expected benefit of treatment, if applicable | | | |
| Are any medications required? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> If yes, what medications? | | | |
| In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Training Instructions <i>(Trainer must be a parent or certified professional)</i> | | | |
| Signature of Trainer | | | Date |
| Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i> | | | |
| Signature | Date | I have been <input type="checkbox"/> Informed | I have been <input type="checkbox"/> Trained |
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| Signature | Date | I have been <input type="checkbox"/> Informed | I have been <input type="checkbox"/> Trained |
| Signature | Date | I have been <input type="checkbox"/> Informed | I have been <input type="checkbox"/> Trained |
| <i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i> | | | |
| Additional services (educational/therapeutic) child is receiving | | | |
| Who provides the above services? | | | |
| Name | Phone Number | May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name | Phone Number | May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

| | |
|----------------------------------|------|
| Parent Signature | Date |
| Administrator/Provider Signature | Date |

Note: A separate plan must be written for each condition that requires different actions to be taken