Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Allergy to: Needs Benedryl and/or Epi-Pen, Jr.

Symptoms to watch for and emergency action to be taken if the following symptoms occur

If any of the above items are ingested and child is showing signs of allergic reaction (i.e. respiratory distress, swelling in neck/throat/face, hive, or vomitting more than 1 time), give __ Benedryl. If still showing symptoms, administer Epi-Pen, Jr. 1)Pull Blue cap off of Epi-Pen, Jr. 2) Swing Epi-Pen, Jr and firmly press orange tip against outer thigh so it clicks 3) Hold 10 sec. 4) Call 9-1-1 and parents

Activities/foods/environmental conditions to avoid, if applicable

Allergy to:

Medical procedures to be followed and expected benefit of treatment, if applicable

If any of the above items are ingested and child is showing signs of allergic reaction (i.e. respiratory distress, swelling in neck/throat/face, hive, or vomitting more than 1 time), give __ Benedryl. If still showing symptoms, administer Epi-Pen, Jr

Are any medications required? ☒ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*

If yes, what medications? Benedryl and/or Epi-Pen, Jr

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?

☐ Yes ☒ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?

☒ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ 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

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