

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

Child's Name		Date of Birth	
Special Health Conditions Asthma			
Symptoms to watch for and emergency action to be taken if the following symptoms occur If child is wheezing/coughing/ or having trouble breathing: Give 2 puffs every 4 hours of Pro-Air/Ventolin with Spacer. To use inhaler w/ spacer 1) Shake inhaler and press one pump. 2) Place inhaler in spacer 3) Place mask on face 4) Press top of inhaler down releasing medication into the spacer 5) Child takes 5-6 long breaths. 6) Wait 1 minute and repeat.			
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> If yes, what medications? Pro-Air/Ventolin Inhaler with Spacer			
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 checked="" 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 checked="" 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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<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