

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 Avi-Q			
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 respiratory distress, swelling in neck/throat/face, hives or vomits more than one time, administer Avi-Q. Pull Avi-Q from outer case, Listen and follow voice instructions. 1. Pull red safety guard down & off 2. Place black end against outer thigh. Push firmly and hold for 2 seconds. Call 911			
Activities/foods/environmental conditions to avoid, if applicable			
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 respiratory distress, swelling in neck/throat/face, hives or vomits more than one time, administer Avi-Q. Call parents and 911 if medication is administered. Medication should lessen symptoms.			
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? Avi-Q			
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> Pull Avi-Q from outer case, Listen and follow voice instructions. 1. Pull red safety guard down & off 2. Place black end against outer thigh. Push firmly and hold for 2 seconds.			
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
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
<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