

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: <span style="float: right;">Needs Benedryl and/or Epi-Pen, Jr.</span>			
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 vomiting 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 5 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, hives, or vomits more than 1 time) give ___ Benedryl If still showing symptoms, administer Epi-Pen, Jr. Medication should make symptoms lessen. Always call 911 and parents when allergic reaction occurs.			
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? 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? <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
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