

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

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

<p>This form shall be completed when a child has a condition that requires one of the following:</p> <ul style="list-style-type: none"> <li>Monitoring the child for symptoms which require staff to take action</li> <li>Ongoing administration of medication or medical foods.</li> <li>Administering procedures which require staff to be trained on those procedures</li> <li>Avoiding specific food(s), environmental conditions or activities</li> <li>School-age child to carry and administer their own emergency medication</li> </ul> <p>If the medication is documented on this form, then a JFS 01217 is not required.</p>	
Child's Name	Date of Birth
<p>Special Health Condition Asthma</p>	
<p>Does the condition require medication?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p><input type="checkbox"/> <b>Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.</b></p> <p>1. What are the symptoms to watch for?  wheezing  coughing  trouble catching breath</p> <p>2. When should the medication or medical food be administered?  If child experiences any of the above symptoms. Inhaler can be given every 4 hours.</p> <p>3. What are the instructions for administration?  Give 2 puffs of inhaler every 4 hours</p> <ol style="list-style-type: none"> <li>1. Shake inhaler</li> <li>2. Place inhaler in spacer</li> <li>3. Place mask on child's face</li> <li>4. Press top of inhaler down releasing the medication into spacer</li> <li>5. Child takes 5-6 long breaths</li> <li>6. Wait 1 minute and repeat</li> </ol> <p>4. What triggers the need for medication or medical foods?  physical activity, illness, weather change</p>	

5. What are the expected results of the medication or medical foods?

Medication should lessen asthma symptoms

6. What are the actions to be taken if symptoms do not subside?

if symptoms do not improve, repeat every 4 hours. If child still has symptoms and it is too soon to repeat inhaler, call parents

7. What are the activities, foods, environmental conditions to avoid?  Not applicable

Training instructions (*include all steps to administer the medication or perform the medical procedure*)

If child experiences any of the above symptoms, give inhaler

Give 2 puffs of inhaler every 4 hours

1. Shake inhaler
2. Place inhaler in spacer
3. Place mask on child's face
4. Press top of inhaler down releasing the medication into spacer
5. Child takes 5-6 long breaths
6. Wait 1 minute and repeat

Included on attached physician's instructions

If expected result of medication or medical food does not occur:

Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? <i>(Check all that apply)</i> <input type="checkbox"/> Medication <input type="checkbox"/> Supplies <input type="checkbox"/> Assistance <input type="checkbox"/> N/A							
<b>Parent Provided Training</b> AND grants permission to perform the procedure  <i>My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i> Parent Signature  Date of Signature		<b>Complete Only One Section</b>	<b>Certified Professional Training</b> AND parent grants permission to perform the procedure  <i>My signature indicates I have provided training for the medical procedure</i>  Certified Professional's Name <i>(please print)</i> Ericka Amabile  Certified Professional's Signature  <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">Date of Signature</td> <td style="width: 50%;">Phone Number 614-559-6239</td> </tr> </table> <i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i> Parent Signature  Date of Signature		Date of Signature	Phone Number 614-559-6239	
Date of Signature	Phone Number 614-559-6239						
Signatures of all child care staff members who have been trained in performing the procedure for this child.							
Printed Name			Signature		Date		
Printed Name			Signature		Date		
Printed Name			Signature		Date		
Printed Name			Signature		Date		
Printed Name		Signature		Date			
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>							
Administrator/Provider Signature			Date of Signature				
This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.							
Parent/Guardian Initials		Date of Review		Administrator/Designee Initials		Date of Review	
Parent/Guardian Initials		Date of Review		Administrator/Designee Initials		Date of Review	
Parent/Guardian Initials		Date of Review		Administrator/Designee Initials		Date of Review	

