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.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Allergy to:

Needs: Benadryl AND Avi-Q

Does this health condition require medication or medical food? ☒ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

Child is allergic to:

Symptoms of allergic reaction:
Hives
Respiratory distress
Swelling in neck/throat/face
Vomitting more than one time

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

Child is allergic to:

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

If child has ingested allergen, first give _____ Benadryl

If child's symptoms are not improving, admister Avi-Q:
1. Pull red safety guard down and off
2. Place black end against outer thigh
3. Push firmly and hold for 2 seconds
4. Call 911

## Part II: Conditions Requiring Medication or Medical Food

**Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

**(If no medications or medical foods are required for the condition, skip Part II).**

**If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.**

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

| Child's Name | Date of Birth | Weight *(if needed to determine dosage)* |
|---|---|---|
| | | |

| Name of Medication/Medical Food | Name of Medication/Medical Food | Name of Medication/Medical Food |
|---|---|---|
| Benadryl | Avi-Q | |
| Dosage of Medication/Medical Food | Dosage of Medication/Medical Food<br>1 injector | Dosage of Medication/Medical Food |
| Time of Medication/Medical Food Administration<br>when allergic reaction occurs | Time of Medication/Medical Food Administration<br>when allergic reaction occurs | Time of Medication/Medical Food Administration |
| Medication/Medical Food Expiration Date | Medication/Medical Food Expiration Date | Medication/Medical Food Expiration Date |

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

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

| Physician's Signature | Date of Signature |
|---|---|
| | |

## Part III: Administration of Medication or Medical Food Training Authorization

**Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)**

**Part III must be completed**

Child's Name

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? *(Check all that apply)*

☒ Medication ☐ Supplies ☐ Assistance ☐ N/A

| **Parent Provided Training** AND grants permission to perform the procedure | **Complete Only One Section** | **Certified Professional Training** AND parent grants permission to perform the procedure |
|---|---|---|
| *My signature indicates I have provided instructions for care and/or 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.* | | *My signature indicates I have provided instructions for care and/or training for the medical procedure* |
| Parent Signature | | Certified Professional's Name *(please print)* Ericka Amabile |
| Date of Signature | | Certified Professional's Signature |
| | | Date of Signature / Phone Number |
| | | *My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.* |
| | | Parent Signature |
| | | Date of Signature |

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

| Printed Name | Signature | Date |
|---|---|---|
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| *My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.* | 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 |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |
| Parent/Guardian Initials | Date of Review | Administrator/Designee Initials | Date of Review |

## Part IV: Documentation of Administration of Medication or Medical Food

**Completed by child care staff member, family child care provider or in-home aide for the child listed on this form**

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

**This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.**

| Child's Name | Name of medication/medical food<br>Avi-Q |
|---|---|

| Date | Time | Dosage | Signature of designated person administering medication |
|---|---|---|---|
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| Child's Name | Name of medication/medical food<br>Benadryl |
|---|---|

| Date | Time | Dosage | Signature of designated person administering medication |
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