

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: Epi-Pen, Jr

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
Vomiting 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, admister Epi-Pen, Jr:

1. Pull Epi-Pen, Jr from outer case
2. Pull off blue cap
3. Swing and firmly press orange tip against outer thigh so it clicks
4. Hold for 5 seconds
5. 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 <i>(if needed to determine dosage)</i>
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Name of Medication/Medical Food Epi-Pen, Jr	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food 1 injector	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration when allergic reaction occurs	Time of Medication/Medical Food Administration	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
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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? <i>(Check all that apply)</i>			
<input checked="" type="checkbox"/> Medication		<input type="checkbox"/> Supplies	
<input type="checkbox"/> Assistance		<input type="checkbox"/> 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	
<i>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.</i>		<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>	
Parent Signature		Certified Professional's Name <i>(please print)</i> Ericka Amabile	
Date of Signature		Certified Professional's Signature	
		Date of Signature	Phone Number
		<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	
Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure 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	
<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
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Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
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