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.

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| 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. * Administering procedures which require staff to be trained on those procedures * Avoiding specific food(s), environmental conditions or activities * School-age child to carry and administer their own emergency medication   If the medication is documented on this form, then a JFS 01217 is not required. | |
| Child's Name | Date of Birth |
| Special Health Condition | |
| Does the condition require medication?  Yes  No | |
| **Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.**  1. What are the symptoms to watch for? | |
| 2. When should the medication or medical food be administered? | |
| 3. What are the instructions for administration? | |
| 4. What triggers the need for medication or medical foods? | |
| 5. What are the expected results of the medication or medical foods? | |
| 6. What are the actions to be taken if symptoms do not subside? | |
| 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)* | |
| 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. | |

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| 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 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 training for the medical procedure* | | | |
| Parent Signature | | | Certified Professional's Name *(please print)* | | | |
| 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 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 |
| *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 | | |
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| The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children. | | | | |
| Child's Name | | | Name of Medication | |
| **Date** | **Time** | **Dosage** | | **Signature of designated person administering medication** |
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