Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE CENTERS & TYPE A HOMES

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

Child's Name

Date of Birth

Special Health Conditions

Symptoms to watch for and Emergency Action to be taken if the following symptoms occur

Activities/Foods/Environmental Conditions to Avoid

Medical Procedures to be followed and Expected Benefit of Treatment

Are any medications required? ☐ No ☐ Yes (If yes, complete JFS 01217 Request for Administration of Medication)

If yes, what medications?

Training Instructions **(Trainer must be a parent/guardian or certified professional)**

Signature of Trainer: **Date:**

Signature of trained staff members and staff who have been made aware of the condition. (There must always be a trained staff member present when the child is present.)

Signature:______________________ Date:__________ ☐ Staff Informed ☐ Staff Trained
Signature:______________________ Date:__________ ☐ Staff Informed ☐ Staff Trained
Signature:______________________ Date:__________ ☐ Staff Informed ☐ Staff Trained
Signature:______________________ Date:__________ ☐ Staff Informed ☐ Staff Trained

(Only trained staff members shall be permitted to perform medical procedures listed above.) Additional staff , may sign on the backside of this form, but need to indicate "trained" and/or "informed".

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name: ______________ Phone number: ______________ May we contact? ☐ No ☐ Yes
Name: ______________ Phone number: ______________ May we contact? ☐ No ☐ Yes

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 Signature		**Date**	