

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

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, if applicable			
Medical procedures to be followed and expected benefit of treatment, if applicable			
Are any medications required? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> If yes, what medications?			
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer			Date
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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/Provider Signature			Date

Note: A separate plan must be written for each condition that requires different actions to be taken



Ohio Department of Job and Family Services
**YOUR PRESCRIPTION FOR SAFELY CARING
FOR CHILDREN WITH SPECIAL HEALTH
CONDITIONS**

After the health care plan has been completed for any child with a special health condition (asthma, allergies, seizure disorders, breathing problems, etc.) the parent/guardian completing the form and the staff member receiving the form should use the check boxes below to verify the child will be cared for safely.

Parent Staff

- The JFS 01236 is complete.
- All staff who are responsible for implementing the health care plan have been trained by the parent/guardian or a certified professional. This includes any staff who are not the child's assigned caregiver but may have responsibilities for the child, such as: opening and closing staff, the administrator, staff who may provide transportation for the child, and substitute staff.
- The parent/guardian completing the form and all trained staff have signed the form.
- If the child needs medication for the health condition, the JFS 01217 has been completed.
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