

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
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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*