

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.

|   |                      |
|---|----------------------|
| <b>Child's Name</b>   | <b>Date of Birth</b> |
| <b>Special Health Conditions</b>  |                      |
| <b>Symptoms to watch for and Emergency Action to be taken if the following symptoms occur</b> |                      |
| <b>Activities/Foods/Environmental Conditions to Avoid</b>                                     |                      |
| <b>Medical Procedures to be followed and Expected Benefit of Treatment</b>                    |                      |

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

**If yes, what medications?**

|  |  |  |  |
|--|--|--|--|
| <b>Training Instructions (Trainer must be a parent/guardian or certified professional)</b>     |  |  |  |
| Signature of Trainer:  |  | <b>Date:</b>   |  |
| <b>Signature of trained staff members and staff who have been made aware of the condition.</b> |  | (There must always be a trained staff member present when the child is present.) |  |

|                  |             |   |  |
|------------------|-------------|---|--|
| Signature: _____ | Date: _____ | <input type="checkbox"/> Staff Informed | <input type="checkbox"/> Staff Trained |
| Signature: _____ | Date: _____ | <input type="checkbox"/> Staff Informed | <input type="checkbox"/> Staff Trained |
| Signature: _____ | Date: _____ | <input type="checkbox"/> Staff Informed | <input type="checkbox"/> Staff Trained |
| Signature: _____ | Date: _____ | <input type="checkbox"/> Staff Informed | <input type="checkbox"/> 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".

|   |  |
|---|--|
| <b>Additional services (educational/therapeutic) child is receiving</b> |  |
| Who provides the above services?  |  |
| Name: _____ Phone number: _____   | May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Name: _____ Phone number: _____   | May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes |

**I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.**

|                                |             |
|--------------------------------|-------------|
| <b>Parent Signature</b>        | <b>Date</b> |
| <b>Administrator Signature</b> | <b>Date</b> |