

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: _____	<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".

Additional services (educational/therapeutic) child is receiving			
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.

Parent Signature	Date	
Administrator Signature	Date	