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

Child's Name								
Special Health Conditions	priter that priters must	a Consideration	West No.					
	nd emergency action to be		20 - 200-159-11475	ng symptom	s occur			
Lavid by head of the life of	nental conditions to avoid,							110
Medical procedures to be  Are any medications requ	followed and expected ber		10 1 Park		gt for	lait-	on of Medication	10.
If yes, what medications? In an emergency does this	s child require additional as							
group) to evacuate?	Yes No care program must be evad							
	ainer must be a parent or cert	ified prof	fessional)	od marico			illo	
Signature of Trainer					Date		Total Control of	
(There must always be a trail Signature	ders, substitutes or child ca ined caregiver present when to	the child i	is present)	ho have bee	I have		the condition.	
Signature		Dat	72		I have	been	Trained I have been	-
Signature	A section of the sec	Dat	te		I have	been	I have been Trained	
Signature		Dat		7	I have	been	I have been	-
	stitutes or child care staff men ational/therapeutic) child is			ted to perfori	m medical <sub>i</sub>	procedu	res listed above.	)
Who provides the above so	ervices?						microside	
Name		Pho	one Number	V	-		May we cont	
Name	H. Targette, and a	Pho	one Number				May we cont	No act?
I give my permission f	for the staff listed above to	perform	the procedi	ures in my o		edical/P	hysical Care P	lan.
Administrator/Provider Sig	gnature	-		paint [1]	Date			/o=
Note: A se	parate plan must be written fo	or each c	ondition that	requires diff	ferent actio	ons to be	taken	
JFS 01236 (Rev. 12/2016)				ed and			afficial south of	
List any history of hospitalization		rious hea	Ith concerns	that would be	e needed to	o assist t	the staff or med	ical
X IDM						15/19	= 7,5% = 3 Milely (==	ra C Isses
List any additional information routines. This information should be a second to the second sec	about your child that would be uld not be medical or health re	e useful fo elated, as	or staff to kno that informa	ow, such as f ition should b	ears, eating e included	g or slee i on the p	eping habits, or s previous page.	peci
	D	lapering	Statement	wir of thirt	8-10 tal		accy else (Negli)	vita
Is your child toilet trained? [following)	Yes (If yes, skip to Emerger	ncy Trans	sportation Au		at los p		f no, fill out the	
The program's policy is to che program's policy or another:								o the
☐ I agree with the program's			ase check my		La transfer	hou	urs.	
Give <u>Permission</u> Program or Home Name	on to Transport		100		Give Perm	nission t	to Transport	
as permission to secure eme	4.0 (5.0 (1.0 (5.0 (5.0 (5.0 (5.0 (5.0 (5.0 (5.0 (5	OI	R does no transpo	ot have perr	nission to	e event	of an illness or it	
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Parent's Signature	Date		Parent's	s Signature			Di	ate
have reviewed and received a	Acknowled a copy of the program's or hor	ne's polic		and Procedu edures/handl	ires	Yes 🗆	No	
		(check	k one)		In U		Secretary 1	
This form, after being complete administrator/designee prior to		uardian, n	nust be revie	wed for com	pleteness	and sign	ed by the	11
Parent/Guardian Signature(s)					- Eggi	Date	Kataliva	(11)
Administrator/Designee Signate	ure	in The	4		-	Date		H
The supplementary and								
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nas stayed the same or change Parent/Guardian Initials	es have been noted. If signific Date of Review		Administra	ded, please of stor/Designed	complete a e Initials	Date of	m. f Review	orma
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JFS 01234 (Rev. 12/2016)

☐ No

Yes - please explain

Medication."

□ N/A - child does not attend a full time program.

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of

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