## Ohio Department of Job and Family Services

## CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

ild'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?			
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?  Yes No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?  [ Yes  No			
Training Instructions (Trainer must be a parent or certified professional)			
Signature of Trainer		Date	
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.  (There must always be a trained caregiver present when the child is present)			
Signature Date	e ·	I have been ☐ Informed	I have been Trained
Signature Dat	2	I have been  ☐ Informed	I have been ☐ Trained
Signature Dat	e	I have been  Informed	I have been ☐ Trained
Signature Dat	e	I have been Informed	I have been ☐ Trained
(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number		May we contact?
Name	Phone Number		May we contact? ☐ Yes ☐ 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