

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Child Medical/Physical Care Plan

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 Condition: _____

Symptoms to watch for:

Conditions to avoid:

Medical Procedures to be followed:

Are any medications required? 9 No 9 Yes

If yes, complete required form ODJFS 1217 Request for Administration of Medication.

Training Instructions: ****Trainer must be parent/guardian or certified professional**

Signature of Trainer: _____ **Date of Training:** _____

Signature of trained staff members:
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____
Signature _____ Date _____ Signature _____ Date _____

Only trained 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? 9 No 9 Yes
Name _____ Phone number _____ May we contact? 9 No 9 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 _____

Annual Review:
Date _____ Admin Initials _____ Parent/Guardian Initials _____
Date _____ Admin Initials _____ Parent/Guardian Initials _____
Date _____ Admin Initials _____ Parent/Guardian Initials _____