

# Medical/Physical Care Plan

This form is required to be completed in full for children with health conditions as defined in Rule 5010:2-12-38.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Special Health Condition: \_\_\_\_\_

Symptoms to watch for: \_\_\_\_\_

Conditions to avoid or that may cause symptoms: \_\_\_\_\_

Medical procedures to be followed: (Be specific) \_\_\_\_\_

Are any medications required? No Yes If yes, complete required form ODJFS 1217 Request for Administrative of Medication.

Is any training necessary? No Yes If yes, please specify \_\_\_\_\_

Training provided by: \_\_\_\_\_

Names of center staff trained \_\_\_\_\_

Trainer must be child's parent/guardian or certified professional

Trainer Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional services (educational/therapeutic) that child is receiving: \_\_\_\_\_

Name and phone number of service provider(s):

\_\_\_\_\_ May we contact provider? yes No

\_\_\_\_\_ May we contact provider? yes No

\_\_\_\_\_ May we contact provider? 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 \_\_\_\_\_

Trained Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Trained Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Trained Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*Only trained Staff Members shall be permitted to perform medical procedures.

Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

Annual Review:

Date \_\_\_\_\_ Admin Initials \_\_\_\_\_ Parent/Guardian Initials \_\_\_\_\_

Date \_\_\_\_\_ Admin Initials \_\_\_\_\_ Parent/Guardian Initials \_\_\_\_\_

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