CARE PLAN FOR HEALTH CONDITIONS, ALLERGIES OR MEDICAL PROCEDURES
FAIRFIELD CHRISTIAN ACADEMY
CHILDCARE & PRESCHOOL

Child's Name:	**Date of Birth:**

Please select one:
Health/Medical Condition ◯ Allergy ◯ Parental Preference ◯

Please describe the health condition/allergy/preference below:

List any activities/foods/environmental conditions to avoid:

Symptoms to watch for and actions to be taken if the symptoms are observed:

Medical procedures to be followed and expected benefit of treatment:

Is any medication required? (If yes, the "Request for Administration of Medication"(attached below), must be completed and signed by physician, in addition to this form.)
Yes ◯ No ◯ Type of medication:_____

Training Instructions (Trainer must be a parent/guardian or certified professional)

Signature of Trainer:	Date

Signature of child care staff members who have been informed about the child's condition so they can care for the child according to this care plan or trained to perform the medical procedure.

There must always be a trained staff member present when the child is present.

Signature	Date	I have been Informed ☐	I have been Trained ☐
Signature	Date	I have been Informed ☐	I have been Trained ☐
Signature	Date	I have been Informed ☐	I have been Trained ☐
Signature	Date	I have been Informed ☐	I have been Trained ☐

Additional Services (educational/therapeutic) child is receiving:
Who provides these services?

Name: _____ Phone Number_____ May we contact? No ◯ Yes ◯
Name: _____ Phone Number_____ May we contact? No ◯ Yes ◯

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan

Parent's Signature	Date
Administrator's Signature	Date

Office of Early Learning and School Readiness

Preschool and School Age Child Care Medication Form

Revised 7/11/2016

This form meets Ohio Administrative Code. Programs may use this form or build their own.

A Medication Form is a request for the administration of prescription and non-prescription medication.

A separate form must be completed for each medication.

Except in cases of emergency, families provide the first dose of any newly prescribed medication so that they may personally observe the child's reaction.

Section I - Request for Administration of Medication

Name of Child		Child's Age	
Medication Name		Dosage	
Staff Authorized to Administer Medication		Dosage Time/s	
Physician Signature		Date	

All prescription medicine must be current within the last twelve months, kept in its original container and have a legible label containing the child's name and written instructions for use from a licensed physician, nurse practitioner, or dentist.

All medicines must be kept in a place inaccessible to children. An inhaler or nonprescription medication may be available to a school child with a special health condition with parental permission in accordance with the program's policy.

Section II - Authorized Staff Member Medication Log

Dosage Date/Time	Dosage Amount	Trained and Authorized Staff Member Signature