



March 16, 2022

**Child Care Manual Procedure Letter No. 151**

**TO: All Child Care Manual Holders**

**FROM: Matt Damschroder, Director**

**SUBJECT: Revised Child Care Forms**

**Background:**

The Ohio Department of Job and Family Services (ODJFS) discovered discrepancies on child care forms that were published to ODJFS Forms Central in October 2021. To better serve child care programs and families of children enrolled, the discrepancies have been corrected and new versions of the forms are being published.

**Amended Forms:**

**JFS 01236 "Child Medical/Physical Care Plan for Child Care"** has been revised to allow more space for writing in each field; to add space to document medications; to separate all the questions on the form into their own fields, including questions related to conditions requiring medication and conditions which do not require medication; and to provide clarity for when a physician needs to complete the form. New language has been added to remind programs that at least one dose of the medication or medical food is to be administered before a medication or medical food can be administered by the program. This does not apply to emergency medications or medical foods. Section headers have been added to specify which individuals need to complete each section. This is a prescribed form.

**JFS 01240 "Food Service License Exemption Report for Child Care Centers"** has been revised to add space for a comment section on the form for local health department representatives to complete when other food service license exemptions are met. Additional changes were made to remove the following option from the form "A food processing establishment provides and serves the food. A copy of the current registration from the Ohio Department of Agriculture is on file at the center" at the request of the Ohio Department of Health and Ohio Department of Agriculture. This is a sample form.

**JFS 01276 "Health Training Documentation for Child Care"** has been revised to match rule language and to remove "licensed athletic trainer" and "first aid trainer" from the list of eligible management of communicable disease trainers. The ODJFS two-hour child abuse and neglect recognition and prevention training was removed from this form, as it is only available through the Ohio Professional Registry. This is a prescribed form.

The most recent version of all ODJFS forms referenced in this procedure letter can be accessed through [Forms Central](#). Programs should begin to use the revised forms as of the date of this procedure letter. Forms completed and currently on file at the program do not need to be updated with these revised versions until they expire or require an update, whichever comes first.

**Questions:**

Please contact the Child Care Policy Helpdesk at [childcarepolicy@jfs.ohio.gov](mailto:childcarepolicy@jfs.ohio.gov) or 1-877-302-2347, option 4, if you have any questions.

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

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

**Part I: Special Health Conditions**  
**Parent must complete all of Part I**

Special Health Condition

Does this health condition require medication or medical food?     Yes (If Yes, complete Part II)     No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid?     Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

**Part II: Conditions Requiring Medication or Medical Food**

**Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

**(If no medications or medical foods are required for the condition, skip Part II).**

**If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.**

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name		Date of Birth	Weight (if needed to determine dosage)
Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food	
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	

**Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature
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**Part III: Administration of Medication or Medical Food Training Authorization**  
**Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)**

**Part III must be completed**

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

Medication       Supplies       Assistance       N/A

**Parent Provided Training** AND grants permission to perform the procedure

*My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.*

Parent Signature

Date of Signature

**Complete Only One Section**

**Certified Professional Training** AND parent grants permission to perform the procedure

*My signature indicates I have provided instructions for care and/or training for the medical procedure*

Certified Professional's Name (please print)

Certified Professional's Signature

Date of Signature

Phone Number

*My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.*

Parent Signature

Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name

Signature

Date

Printed Name

Signature

Date

Printed Name

Signature

Date

Printed Name

Signature

Date

Printed Name

Signature

Date

*My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.*

Administrator/Provider Signature

Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials

Date of Review

Administrator/Designee Initials

Date of Review

Parent/Guardian Initials

Date of Review

Administrator/Designee Initials

Date of Review

Parent/Guardian Initials

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Date of Review

Administrator/Designee Initials

Date of Review



Ohio Department of Job and Family Services  
**FOOD SERVICE LICENSE EXEMPTION REPORT  
 FOR CHILD CARE CENTERS**

Each center is required to verify their exemption from food service licensure by providing a written statement from the health official with jurisdiction in the area in which the center is located.

Center	
Address	
City	State
Zip Code	County

The above named center does not require licensure as a food service operation under Chapter 3717. of the Ohio Revised Code because the center (*check as applicable*)

Prepares and/or serves no food

Prepares and/or serves food to thirteen or fewer individuals daily

Comment

The child care center operator is responsible for contacting the local health department having food service licensing jurisdiction should there be any changes in their food program.

Signatures	
Child Care Center Administrator or Authorized Owner Representative	Date
Health Department Representative	Date

Prepared by Ohio Department of Job and Family Services in cooperation with the Ohio Department of Health and the Ohio Department of Agriculture

Ohio Department of Job and Family Services  
**HEALTH TRAINING DOCUMENTATION FOR CHILD CARE**

<b>(TRAINERS MUST FILL IN NAME OF PERSON BEING TRAINED. DO NOT HAND OUT WITHOUT COMPLETING THIS BOX).</b>		
Name of Person Being Trained		
<b>Training Type</b>		
<input type="checkbox"/> First Aid <input type="checkbox"/> Management of Communicable Disease  <input type="checkbox"/> CPR <input type="checkbox"/> Child Abuse and Neglect Recognition and Prevention (CAN)		
Date(s) of Training	Number of Hours	Expiration Date
<input type="checkbox"/> Exempt (I am a child care staff member, child day camp staff member, or in-home aide and meet the trainer requirements in rule 5101:2-12-10, 5101:2-13-10, 5101:2-14-03 or 5101:2-18-08 of the Administrative Code for the applicable training checked below). Attach proof of certification that verifies trainer requirements have been met. <input type="checkbox"/> First Aid <input type="checkbox"/> CPR <input type="checkbox"/> Management of Communicable Disease		
<b>Trainer Requirements</b>		
<b>First Aid</b>		
<input type="checkbox"/> Advanced Practice Registered Nurse <input type="checkbox"/> Licensed Athletic Trainer <input type="checkbox"/> Certified Nurse Practitioner <input type="checkbox"/> Licensed Physician <input type="checkbox"/> Currently certified First Aid Trainer <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Emergency Medical Services Instructor <input type="checkbox"/> Registered Nurse		
<b>CPR</b>		
<input type="checkbox"/> Currently certified CPR Instructor <input type="checkbox"/> Emergency Medical Services Instructor		
<b>Management of Communicable Disease</b>		
<input type="checkbox"/> Advanced Practice Registered Nurse <input type="checkbox"/> Licensed Physician <input type="checkbox"/> Certified Nurse Practitioner <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Current trainer employed by local health department <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Emergency Medical Services Instructor		
<b>Child Abuse and Neglect Recognition and Prevention</b>		
<input type="checkbox"/> An associate degree (or higher) in an approved field with 2 years of experience professionally assessing child abuse and neglect, providing counseling to abused children, training others in child abuse prevention, or a combination of experience and training <input type="checkbox"/> Authorized trainer for a Public Children's Services Agency (PCSA) <input type="checkbox"/> Advanced Practice Registered Nurse* <input type="checkbox"/> Certified Nurse Practitioner* <input type="checkbox"/> Licensed Physician* <input type="checkbox"/> Physician's Assistant* <input type="checkbox"/> Registered Nurse* <small>*With 2 years of experience professionally assessing child abuse and neglect, providing counseling to abused children, training others in child abuse prevention, or a combination of experience and training</small>		
<b>Trainer Verification and Signature</b>		
I verify that the training meets the requirements outlined in rule 5101:2-12-10, 5101:2-13-10, 5101:2-14-03, or 5101:2-18-08 of the Administrative Code. The information on this form is true and accurate.		
Name of Trainer (please print)	Signature of Trainer	Date
Address	Email Address	Telephone Number