JCC *of* Greater Dayton
Health Questionnaire

Name of Camper: Date:

Insurance Information

Name of Physician: Phone:

Name of Dentist: Phone:

Insurance Company Name: Policy No.

Name of Policy Holder: Relationship to Child:

List of any medications:

1.
2.

List any allergies:

1.
2.

Describe any health problems we need to be aware of. List any activities the child should be exempted due to health reasons.

Please explain the child's history of hospitalization and past medical treatments:

Are there any physical or mental disabilities that we should be aware of?

Are there any medical conditions we need to be award of?

Any additional information we should be aware of?

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth
☐ This above named child has been examined and is in suitable condition for participation in group care.	
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician /Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

	Physician /Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner Completes *check all that apply*			
Diseases for Immunization	**Immunization In Process or Complete**	**Medically Contraindicated**	**Not Medically Appropriate for Age of Child**	**Parent Declined** *Check any that have been declined and sign below*
Chicken pox	☐	☐	☐	☐
Diphtheria	☐	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐	☐
Measles	☐	☐	☐	☐
Mumps	☐	☐	☐	☐
Pertussis	☐	☐	☐	☐
Pneumococcal disease	☐	☐	☐	☐
Poliomyelitis	☐	☐	☐	☐
Rotavirus	☐	☐	☐	☐
Rubella	☐	☐	☐	☐
Tetanus	☐	☐	☐	☐

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

☐ I have declined to have my child immunized against one or more of the disease listed above for reasons of conscience, including religious convictions.

Signature of Parent

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION

Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of child:_____ Date of birth: _____Weight: _____

Name of medication:_____ Exact dosage: _____

To be administered at the following times_____

For the following period of time:_____

Parent/Guardian signature:_____ Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (May not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of OAC rules 5101:2-12-31 and 5101:2-13-31

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on page 2 of this form.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication

This form must be used by child care centers and type A homes to meet the requirement of OAC rules 5101:2-12-31 and 5101:2-13-31

Reset Form

Ohio Department of Job and Family Services

CHILD CARE PLAN FOR HEALTH CONDITIONS OR MEDICAL PROCEDURES FOR CHILD CARE CENTERS AND TYPE A HOMES

If care is provided for a child who has an ongoing health condition that requires child specific care or may require a medical procedure, the parent/guardian shall complete this form. The center staff shall implement the plan. This requirement does not include short term illnesses, unless the child care staff member needs to perform a medical procedure for the child. A separate plan must be written for each condition that requires different actions to be taken.

Child's Name	Date of Birth

Describe the health condition.

Describe the medical procedure to be completed and expected benefits of treatment, or ☐ N/A, no medical procedure required.

List activities/foods/environmental conditions to avoid or ☐ N/A, nothing to avoid.

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

Is any medication required? ☐ Yes ☐ No
(If yes, complete JFS 01217 "Request for Administration of Medication", in addition to this form.)

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 If yes, please describe:

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 If yes, please describe:

Signature of Trainer (Trainer must be a parent/guardian or certified professional)	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	☐	☐
Signature	Date	☐	☐
Signature	Date	☐	☐

I give my permission for the staff listed above to perform the procedures in my child's care plan as described above.

Parent's Signature	Date

Administrator's Signature	Date

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.