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?

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Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year*)

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____
Dental: ☐ Yes ☐ No Date: _____
BMI: ☐ Yes ☐ No Date: _____
Hearing: ☐ Yes ☐ No Date: _____
Lead: ☐ Yes ☐ No Date: _____
Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

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

<u>Box 3</u> - The section below must be completed by the **center or type A home staff** and <u>each administration</u> of medication must be documented. **<u>All</u>** 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.