Montgomery Nursery School
a ministry of Church of the Saviour United Methodist

Food Allergy and Care Plan Information

The State of Ohio requires Montgomery Nursery School to have very specific documentation regarding children who have food allergies or another form of special need. The reason for this paperwork is so that we can best meet the needs of every child, as well as to help the Montgomery Nursery School staff to keep your child safe every day while at school.

If your child has a food allergy, it is important for that to be noted on the **Child Enrollment Form**. Montgomery Nursery School needs to have as much information about the allergy as possible, which can be shared on the **Child Medical/Physical Care Plan**.

If your child's condition could require the distribution of emergency medication (either over the counter or prescription) the **Request for Administration of Medication** must be completed for each medication.

- A portion of this form must be **completed and signed** by a licensed physician, licensed dentist, advanced practice registered nurse, or certified physician's assistant.
- All medication must be in the **original packaging** when it is returned to us—leave Benadryl in the box, bring the epi-pen in its container with the prescription label.

Please use the attached pages as a sample and guide for completion of these forms. If the medication your child uses comes with manufacturer's instructions, we would love to make a copy of them to keep with the medication. Remember, the more details you can provide for us, the better! We are committed to keeping children safe.

Allergy forms should be completed and turned in on your child's meet the teacher event (the week of August 27). Your child may not begin school until all forms are complete and emergency medication is on site.

If you have any questions at all, please contact the office and we will be happy to help you.

Montgomery Nursery School
erin.sprang@cos-umc.org
984-1796

* SAMPLE FORM *

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth
Tommy Kidd	1/11/2015

Special Health Conditions
Allergy to Peanuts (Medical Diagnosis)

Symptoms to watch for and emergency action to be taken if the following symptoms occur
Difficulty breathing, excessive coughing, swollen lips or tongue, hives → Give Benadryl and inject epipen into thigh. Call 911 and parents.

Be as specific as possible!

Activities/foods/environmental conditions to avoid, if applicable
Peanuts, including oils

Medical procedures to be followed and expected benefit of treatment, if applicable
Give Benadryl. Inject epipen into outer thigh as indicated on instructions. Hold for 3 sec. Symptoms should subsi

Are any medications required? ☑ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications? Benedryl and Epi-Pen

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

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

Training Instructions *(Trainer must be a parent or certified professional)*
Remove Epi-pen from tube. Remove cap. Push pen into outer thigh which will release needle. Hold for 3 seconds.

If you have instructions from manufacturer, you may attach a copy

Signature of Trainer	Date
Mother Kidd	8/25/18

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been Informed	I have been Trained
Abbey Administrator	8/25/18	☑	☑
Tammy Teacher	8/25/18	☑	☑
Amanda Assistant	8/25/18	☑	☑
		☐	☐

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving N/A

Who provides the above services?
N/A

Name	Phone Number	May we contact?
		☐ Yes ☐ No
		☐ 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
Mother Kidd	8/25/18
Administrator/Provider Signature	Date
Abbey Administrator	8/25/18

Note: A separate plan must be written for each condition that requires different actions to be taken

* SAMPLE FORM: one form per medication

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information. Medication must be in the original packaging

- ☐ Prescription Medication
- ☑ Nonprescription Medication
- ☐ Food Supplement
- ☐ Topical Product or Lotion
- ☐ Refrigeration Required
- ☐ Modified Diet

Name of Child	Date of Birth	Weight
Tommy Kidd	1/11/2015	26 lbs.

Name of Medication	Exact Dosage
Benedryl * Must be exactly what Dr. writes - if Benadryl, must be name brand *	5 mL

To be administered at the following times	For the following period of time
When difficulty breathing, excessive coughing, swollen lips, or hives appear	1 year ← updated annually or if change in dosage occurs

☑ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

we cannot be the 1st administration

Signature of Parent/Guardian	Date
Mother Kidd	8/25/18

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement *
Dosage 5 mL	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

Must match Dr. Portion below

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

SAMPLE FORM

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☑ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight
Tommy Kidd	1/11/2015	26 lbs.

Name of Medication	Exact Dosage
Epi-pen Jr.	0.15 mg (one pen)

To be administered at the following times	For the following period of time
after exposure to peanuts/oil when difficulty breathing, excessive coughing, swollen lips, or hives appear	1 year

☑ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date
Mother Kidd	8/25/18

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement
	Epi-pen Jr.
Dosage: 0.15 mg (one pen)	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

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Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and emergency action to be taken if the following symptoms occur	
Activities/foods/environmental conditions to avoid, if applicable	
Medical procedures to be followed and expected benefit of treatment, if applicable	
Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")* If yes, what medications?	
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	
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	
Training Instructions *(Trainer must be a parent or certified professional)*	
Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained
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(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving		
Who provides the above services?		
Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ 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
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

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

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

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5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

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