Dear Parents:

We require and provide a safe environment for our students. Our food policy is contained in the handbook on page 4. We welcome students with food allergies, but in connection with providing this environment, we require the execution of the attached release.

If you have any further questions regarding this matter please contact myself or the preschool board.

Sincerely,

Julie E. Stroup

Allergy Release

In consideration of services provided or to be provided by Indian Run United Methodist Church Preshool, (here in after *IRUMCP) and all agents or employees of IRUMCP, including, but not limited to its Director, Advisory Board Members, and teachers, (here in after collectively referred to as "releasees"), the undersigned parent(s) or guardian(s) (hereinafter referred to as "Releasor(s) voluntarily and knowingly execute this form with the express intention of effecting the extinguishment of obligations as herein set forth.

Releasor(s), with the intention of binding him/herself, his/her spouse , his/her minor children, heirs, legal representatives, successors and assigns, expressly release and forever discharges each and all the Releasees from any and every present and future claim, demand, action or right of action of whatsoever kind, either in law or in equity, arising from or by reason of any bodily injury or personal injuries know or unknow, death and/or property loss resulting or to result from any exposure to or ingestion of any food allergen which occurs during attendance at IRUMCP by _____(student's name)

Or during that student's participation in any activities conducted by or at the direction of any or all of the Releasees or student of IRUMCP.

Releasor(s) assumes full responsibility for and risk of bodily injury, death, or property incurred by_____(student's name) as a result of the above-described activities and services, whether said injury, death, or loss of result from negligence or otherwise.

Releasor expressly agrees that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Ohio and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Releasor(s) states that he/she has read the foregoing Release, knows the contents thereof and signs this form of his/her own free act.

Printed Name of Releasor (Mother or Father or Legal Guardian)

_____Date

Signature of Releasor (Mother or Father or Legal Guardian)

Medical Policy

All medication that will be kept at preschool must go to the director's office to be checked.

1. Medical forms completed.
(IRP Release, ODJFS 01217, ODJFS 01236)
    A. Signed by parent and director.
    B. If training required parent will train the staff on the medication.
2. Medical care plan completed. (ODJFS 01236)
    A. Signed by parent and director.
    B. If training needed parent will train the staff on the medication.
3. Check and record dates of expiration on medication on master allergy list.
4. All over the counter medication must be in original package with dosage directions visible, child's full name needs to written on container.
    A. Make sure dosage states allowed for child's current age
        a. If child's current age is not listed then ODJFS form 01217 needs to be completed by the physician bottom half of form.
        b. If directions state dosage for the child's current age then parent can sign ODJFS form 01217 top half.
    B. All over the counter medication needs to have an expiration date at least one year from the time it is given to Indian Run Preschool.
5. All prescription medication must be in original container with label attached, with specific dosages. If medication has multiple pieces (i.e. Epi pen or inhaler) make sure an additional label is on the actual medication. Child's full name must be on the container.
6. All medication and medical care plans will be reviewed by our preschool board member who is an RN. This will help to insure that all forms are completed correctly.
7. Once all medication has been checked a label will be made and all of the child's medication will be in one zip-lock bag with label attached to outside of the bag. A copy of all forms will be included in the child's medication bag.
8. Medication will then be given to classroom for teachers to review and sign form ODJFS 01236 and be trained by parent if needed.
9. Monthly review of medication and all paperwork as well as expiration dates on master allergy list; on first working day of month by administration.
10. The school will document when medication is administered on ODJFS form 01217.
11. Medication shall be stored out of reach of children.
12. Medication must be administered to the correct child, in the correct amount at the correct time.
13. All parents will be notified properly.

Ohio Department of Job and Family Services

YOUR PRESCRIPTION FOR SAFELY ADMINISTERING PRESCRIPTION MEDICATION

JFS 01580 (Rev. 12/2016)

After the JFS 01217 is complete, the parent/guardian who completed the form and the staff member receiving the form should use the check boxes below to verify the medication can safely be administered.

Parent	Staff	
☐	☐	Original prescription label is attached.
☐	☐	Date on the prescription label is within the last 12 months.
☐	☐	A licensed physician, licensed dentist, or an advance practice nurse has completed Box 2 of the JFS 01217 for sample medication that does not have a prescription label attached.
☐	☐	Every item in Box 1 of the JFS 01217 has been filled in.
☐	☐	The instructions on the label exactly match the information in Box 1 of the JFS 01217 for the dosage amount and time for medication to be given.
☐	☐	If the medication is needed for a health condition such as asthma, allergies, seizure disorders, breathing problems, etc., a health care plan has been completed.
☐	☐	At least one dose already administered to child at home

Ohio Department of Job and Family Services

YOUR PRESCRIPTION FOR SAFELY ADMINISTERING NON-PRESCRIPTION MEDICATION

JFS 01581 (Rev. 12/2016)

After the JFS 01217 is complete the parent/guardian who completed the form and the staff member receiving the form should use the check boxes below to verify the medication can safely be administered.

Parent	Staff	
☐	☐	The medication is in its original container.
☐	☐	The medication has not expired.
☐	☐	A licensed physician, licensed dentist, or an advance practice nurse has completed Box 2 of the JFS 01217 for medication which indicates a doctor must be consulted based on the child's age/weight, or Amount and time of dosage completed in Box 1 of the JFS 01217 exactly matches the instructions from the manufacturer based on the child's age/weight.
☐	☐	Every item in Box 1 of the JFS 01217 has been filled in.
☐	☐	If the medication is needed for a health condition such as asthma, allergies, seizure disorders, breathing problems, etc., a health care plan has been completed.

Ohio Department of Job and Family Services

YOUR PRESCRIPTION FOR SAFELY CARING FOR CHILDREN WITH SPECIAL HEALTH CONDITIONS

JFS 01582 (Rev. 12/2016)

After the health care plan has been completed for any child with a special health condition (asthma, allergies, seizure disorders, breathing problems, etc.) the parent/guardian completing the form and the staff member receiving the form should use the check boxes below to verify the child will be cared for safely.

Parent	Staff	
☐	☐	The JFS 01236 is complete.
☐	☐	All staff who are responsible for implementing the health care plan have been trained by the parent/guardian or a certified professional. This includes any staff who are not the child's assigned caregiver but may have responsibilities for the child, such as: opening and closing staff, the administrator, staff who may provide transportation for the child, and substitute staff.
☐	☐	The parent/guardian completing the form and all trained staff have signed the form.
☐	☐	If the child needs medication for the health condition, the JFS 01217 has been completed.

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.

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	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

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.

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

(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

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