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

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

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

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	**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 and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		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 proced 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	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

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

Name of medication	Dosage	
	☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (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 when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription 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

Instructions

☐ See Attached

Possible side effects to watch for are

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

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

Phone Number

This form shall be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication