# PRE-ENROLLMENT REVIEW FOR CHILDREN WITH IDENTIFIED HEALTH OR DEVELOPMENTAL CONDITIONS

Child's Name: _____ DOB: _____
Parent/Guardian Name: _____
Telephone: _____ Email: _____
EHS/HS Site: _____ Application Date: _____

**ATTACH:** Completed Authorization to Release Information form for providers (as applicable: physician, school district, Regional Center, Rady Children's, etc.) and IFSP/IEP (if applicable)

| **Health and Nutrition** (To be completed by EHS/HS Staff at intake) ☐ **N/A** |
|---|
| **Person Completing Intake, Title:** _____ |
| Child's Health/Nutrition Need(s) (Be as specific as possible)<br>Health Condition: ☐ Epilepsy ☐ Diabetes ☐ Severe Asthma ☐ Feeding Tube ☐ Severe Allergies<br>☐ Feeding or Eating Disorders ☐ Cancer ☐ Other _____ |
| Medications and/or Adaptive Equipment: ☐ N/A |
| Additional Comments: |

_____ _____ _____
Print Name, EHS/HS Staff | Signature, EHS/HS Staff | Date

**FSS/EHS PA/HB Supervisor:**
**Status Recommendation:** ☐ **Prioritization List** ☐ **EHS/HS Applied** - PECC and/or follow up needed

Family Service Supervisor/EHS Program Assistant Verification Date ____/____/____
Family Service Supervisor/EHS Program Assistant Name:_____
Signature_____
Date Service Request submitted to CSQI Program Support (if applicable) ____/____/____

| **Developmental/Mental Health** (To be completed by Area ECE/Disability Specialist) ☐ **N/A** |
|---|
| Identified Disability (IEP/IFSP)? ☐ Yes ☐ No |
| A. Primary disability: Current IEP/IFSP Date: _____<br><br>Services: (Indicate types and service length) :<br><br>Part B/C Provider: Has Specialized Academic Instruction ☐ Yes ☐ No |
| B. Non-IEP/IFSP related Disability or Mental Health (Social-Emotional/Behavioral) Concern:<br>*For example: Healthy Developmental Services, Rady Children's KidStart, PCIT, ABA, CWS involved, etc.*<br>☐ Yes ☐ No ☐ N/A |
| Additional Comments: |

**Area ECE/Disabilities Specialist:**
**Status Recommendation:** ☐ **Prioritization List** ☐ **EHS/HS Applied** - PECC and/or follow up needed

_____ _____ _____
Print Name, ECE/Disabilities Specialist | Signature, ECE/Disabilities Specialist | Date

**Filing:**
Child File: Original Health Plan, IFSP/IEP, Developmental Documentation, Service Request, Pre-Enrollment Review
Attach to Intake/Application: Copy of complete IFSP/IEP, Copy of Pre-Enrollment Review form
Send to Area ECE and CSQI Program Support Disabilities, Health, Mental Health, or Nutrition Coordinator (as applicable): Service Request, Health, Nutrition, and/or Developmental Documentation, Authorization to Release Information, IFSP/IEP