PY 55 EHS New Child Service Packet

Cover:

- 0.0 Child File Cover Sheet
- 0.1 Emergency Contact Information

Section 1: Enrollment

- Progress Notes
- 1.1 Annual Enrollment Questionnaire
- 1.2 Document Receipt Acknowledgement
  - 20 Facts About Child Abuse (PUB 411) (give copy to parent)
  - Caregiver Background Check (LIC 995E) (give copy to parent)
- 1.3A EHS/CDE Full Day
- 1.3C Attendance/Drop Off/Pick Up Policy (give copy to parent)
- 1.4 Pre-Enrollment Review
- 1.6 Parents' Rights (LIC 995) (give copy to parent)
- 1.7 Personal Rights (LIC 613A) (give copy to parent)

Section 2: Health and Nutrition

- Progress Notes
- 2.1 Immunization Record (Blue Card)
- 2.2 Health Consent and Acknowledgement Form
- 2.3 Child's Preadmission Health History (LIC 702)
- 2.4A Well Baby Form (give copy to parent; 1 – 15 months)
- 2.4B Toddler Physical (give copy to parent; 18, 24, 30 months)
- 2.5 Dental Health Form (give to parent; 24+ months)
- 2.6A Infant Nutrition Health Questionnaire
- 2.6B Toddler Nutrition Health Questionnaire

<u>The following Health and Nutrition Forms are only if applicable (* = give copy to parent)</u>

- 2.8A Request for Special Meals and/or Accommodations – Medical Statement*
- 2.8B Request for Special Meals and/or Accommodations – Parent/Guardian*
- 2.9 Medication Intake Form
- 2.11A Authorization to Administer Medication at School*
- 2.11B Individual Health Plan – IHP
- 2.13 Parent Consent for Application of Diaper Rash Cream/Ointment or Sunscreen*
- Authorization to Release Information

Section 4: Education

- 4.6 Parent/Home Visitor Agreement (Home-Based Only)

Section 5: Disabilities

- Authorization to Release Information

NEIGHBORHOOD HOUSE ASSOCIATION

Program Type: ☐ Early Head Start ☐ Head Start

Program Option: ☐ Home-Based ☐ Full Day ☐ Part Day (□AM □PM)

☐ New ☐ Returnee

Child's Full Legal Name	Date of Birth	FID#	PID#

Initial Date of Attendance in Program (EHS or HS): _____

Date of PROMIS Status Start Date PY 55: _____

1st Day of Attendance (DOA) PY 55: _____

1st Home Visit PY 55 (HB option only): _____

(A) Parent/Guardian Name: _____

**See Emergency Contact Information form for address, phone number, and email*

Primary Language: _____

Does the enrolled child live with Parent/Guardian (A)? ☐ Yes ☐ No

☐ **Court Order on File (i.e. Custody, Restraining orders, Guardianship)**

(B) Parent/Guardian Name: _____

**See Emergency Contact Information form for address, phone number, and email*

Primary Language: _____

Does the enrolled child live with Parent/Guardian (B)? ☐ Yes ☐ No

☐ **Court Order on File (i.e. Custody, Restraining orders, Guardianship)**

Due dates based on child's first DOA

30	____/____/____
45	____/____/____
60	____/____/____
90	____/____/____

EMERGENCY CONTACT INFORMATION

Site: _____ Teacher's Name: _____ Room#: _____ FID#_____

Child's Full Legal Name _____ Male ☐ Female ☐ Birth Date: _____ /_____ / _____

A. Name of parent/guardian _____ ☐ Child lives with parent

Contact Phone: (_____) _____ Alternate Phone or Work Phone: (_____) _____

Address: _____

Email address of parent/guardian: _____

B. Name of parent/guardian _____ ☐ Child lives with parent

Contact Phone: (_____) _____ Alternate Phone or Work Phone: (_____) _____

☐ Same as above or Address: _____

Email address of parent/guardian: _____

Is there any person(s) NOT authorized to pick child up from school? (If yes, court order must be in Child File)

☐NO ☐ YES, Name of Person _____

Medical Insurance Type: ☐ Medi-Cal ☐ CHDP ☐ TriCare ☐ Private ☐Other: _____ ☐ None

Insurance Provider: _____ I.D.#: _____ Issue/Effective Date: _____

Physician: _____ Address: _____

Phone: (_____) _____ Fax: (_____) _____

Dental Insurance Type: ☐ Medi-Cal/Denti-Cal ☐ CHDP ☐ TriCare ☐ Private ☐Other: _____ ☐ None

Dental Insurance Provider _____I.D. # _____ Issue/Effective Date: _____

Dentist: _____Address: _____

Phone: (_____) _____ Fax: (_____) _____

HEALTH INFORMATION

Circle any of the following conditions that apply to the child: Food Allergy, Special Diet, Asthma, Diabetes, Anemia, Sickle Cell, Seizure, Fainting, Epilepsy, Heart Condition, Severe allergy, Other_____ ☐ N/A

Details & Reactions (please explain) _____

Are any of the above life-threatening? ☐ No ☐ Yes if yes, please explain: _____

Physician/Specialist's name and phone number: _____(___)_____

Medications that child uses/takes at school: _____

IN THE EVENT OF AN EMERGENCY

In the event of an emergency during which there is a belief that my child's life may be at risk, or a belief there is a risk of permanent injury to my child, I understand that NHA staff will call Emergency Medical Services and provide necessary treatment for my child's urgent medical care. In the case of an emergency incident, I authorize NHA to engage Emergency Medical Services, provide necessary treatment, and to share my child's health records with emergency service providers. I understand that I will be immediately notified of an emergency situation.

Parent/Guardian's Signature: _____ Date: _____ /_____ /_____

OTHER PERSONS AUTHORIZED TO PICK UP CHILD FROM EHS/HS SITE

Name_____ Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

☐ Additional names have been added to the back of this document.

Print Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____ /_____ /_____

ANNUAL ENROLLMENT QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN MEETING YOUR CHILD AND FAMILY'S NEEDS:

Child's Name:_____ Date of Birth: _____ /_____ /_____

1. Was your child born premature? ☐ Yes ☐ No If **yes**, how many weeks early was child born? _____
   Was your child admitted to the NICU? ☐ Yes ☐ No

2. Is your child currently receiving any prescribed medication? ☐ Yes ☐ No
   For (diagnosis) _____
   Prescribed by _____ Phone ( )_____
   Does medication need to be taken during school hours? ☐ Yes ☐ No
   Does this medication have any side effects? ☐ Yes ☐ No If yes, please describe: _____

3. Is your child allergic to any food or require a special diet? ***(This does not include dislikes of certain foods)*** ☐ Yes ☐ No
   If yes, which? _____Reaction _____
   Physician's Name _____ Phone_____

4. Does your child have any feeding problem or require any special adaptive equipment, including feeding utensils?
   ☐ Yes ☐ No **If yes, which**_____

5. Has your child ever tested positive for TB? ☐ Yes ☐ No
   If **yes**, has or is he/she now taking INH medication? ☐ Yes ☐ No
   Date of last X-ray _____ Result of X-Ray _____

6. Does your child have a clinically diagnosed disability or receive services for any of the following? ☐ Yes ☐ No
   ☐ Speech/language therapy ☐ Physical therapy ☐ Occupational therapy ☐ Behavior Therapy
   ☐ Hearing impairment ☐ Vision impairment ☐ Dietitian services
   ☐ Mental Health services (i.e.-Healthy Developmental Services, Rady's Childrens's KidStart, PCIT, ABA, JFS

7. Does your child have an Individual Education Program (I.E.P.)? ☐ Yes ☐ No
   or Individual Family Service Plan (I.F.S.P.)? ☐ Yes ☐ No

8. Is your child/family currently receiving disability services from another agency? ***(Regional, Alcott, etc.)*** ☐ Yes ☐ No
   If **yes**, who and why? _____

9. Is the child you are enrolling in foster care or receiving services from Child Welfare Services (CWS)? ☐ Yes ☐ No
   If **yes**, provide CWS Worker's Name _____ Phone _____

10. Is your child/family currently receiving social services from any agency ***(If yes, see options below)***? ☐ Yes ☐ No
    ☐ WIC ☐ Medi-Cal ☐ SSI ☐ TANF ☐ SNAP/CalFresh ☐ Other: _____

11. Are you or the child's other parent/guardian a member in the U.S. Military? ☐ Yes ☐ No
    If **yes**, are they currently deployed? ☐ Yes ☐ No

12. Is your family homeless, in transitional living, or do you have housing concerns? ☐ Yes ☐ No
    If **yes,** please explain: _____

13. Is your child entering Transitional Kindergarten/Kindergarten next school year? ☐ Yes ☐ No
    If **yes**, provide "Kindergarten Here I Come!" handout and initiate Kindergarten Transition Checklist

Parent Name (print)	Parent Signature	Date
Staff Name (print)	Staff Signature	Date
Site Supervisor (print)	Site Supervisor Signature	Date

DOCUMENT RECEIPT ACKNOWLEDGEMENT

Child's Name: _____ Date of Birth: _____

Site/Program Option: _____

#	Permissions	Initials
1	I grant permission to Neighborhood House Association to photograph and/or record (audio and video) my child for use in my child's portfolio, classroom, and site.	☐ I consent: _____ ☐ I don't consent: _____
2	I grant permission to Neighborhood House Association to photograph and/or record (audio and visual) me and/or my child. I understand such recordings and images will be used solely by NHA for educational, charitable and promotional activities conducted by NHA without monetary compensation provided to me. ***** Foster children/dependents of the County of San Diego MUST NOT be photographed or recorded for public/promotional use. Foster parents/kinship caregivers MAY NOT give permission for public/promotional photography or recording. *****	☐ I consent: _____ ☐ I don't consent: _____
3	I grant permission to Neighborhood House Association to post photographs or video of myself, my family, or my child on NHA's social media pages (ex. NHA Parent Facebook Group Page).	☐ I consent: _____ ☐ I don't consent: _____

#	Information and/or Resources Provided	Initials
4	Parent Handbook (provide Head Start Resource Card)	
5	NHA School Readiness Calendar	
6	20 Facts About Child Abuse	
7	LIC 995E – Caregiver Background Check (Center-Based only)	☐ N/A
8	EHS Transition and Eligibility Letter (EHS only)	☐ N/A
9	Over-Income Parent Acknowledgement Letter (if applicable)	☐ N/A

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

CONTRACT HOURS AGREEMENT

Early Head Start/Head Start & California Department of Education
Full Day Only

Child's Name: ________________________________ Site: ______________ FID#_________

The State of California requires that all childcare sites maintain adequate staff to child ratios at all times. In order to ensure that these ratios are met, and to ensure the health and safety of the children, Neighborhood House Association requires that all parents adhere to contract hours for services.

Your contract hours are based on the hours that you need childcare. The agency will allow travel time to and from work or school and study time, if requested. If you request study time and are enrolled in an Education/Training Program leading to a recognized Trade/Vocation you will be approved for up to 1 hour of study time per unit/credit hour you spend in class (i.e. 12 units = 12 hours of study time).

Please check here if you need: ☐ Travel Time _______ hrs./min ☐ Study Time _______ hrs./min

It is your responsibility to inform us if your work or school schedules change in any way.

- -

Day of the week	Actual Hours of Attendance
Monday	From: __________ To: ____________
Tuesday	From: __________ To: ____________
Wednesday	From: __________ To: ____________
Thursday	From: __________ To: ____________
Friday	From: __________ To: ____________

Please check the box that indicates the parent's NEED for our services:

Employment ☐ Training/Education Program ☐ Seeking Employment ☐

Seeking Permanent Housing ☐ Statement of Incapacitation ☐ Child Welfare Services/At Risk ☐

I agree to abide by the hours above. If I need to increase or decrease the hours of my child's attendance, I will notify the Site Supervisor. If I fail to consistently pick up my child on time, a case conference may be held to determine appropriateness of placement for my child's current program option.

**** * Failure to comply with scheduled contract hours may result in the implementation of the agency's Drop/Transfer Policy. * ****

Print Parent/Guardian Name: ____
Signature: ___________________________ Date: ___________________________
Print Staff Name: ____
Signature: ___________________________ Date: ___________________________

ATTENDANCE/DROP-OFF/PICK-UP POLICY

Daily attendance is important for young children to learn daily routines, make friends, and develop skills that will help them succeed in school and throughout their lives. You are required to report your child's absence to your site within one (1) hour of your scheduled drop-off time.

Drop-Off: We expect your child to arrive at school on time every day, per your contract hours. It is important that you bring your child to school on time every day so that they can receive the full benefit of the school day. If a child is regularly being dropped off late the child may be transferred to a more appropriate program option (i.e. Home Base/Part Day).

Pick-Up: It is important that children are picked up promptly when their contract hours end each day. Emergency contacts will be called for any child who is not picked up by the end of contract hours. If Staff is unable to reach an authorized adult, the police may be contacted to take custody of the child. If a child is regularly picked up late the child may be transferred to a more appropriate program option (i.e. Home Base/Part Day).

If there are any changes to your emergency contacts during the program year you must make changes in person with the site staff to update your emergency card information. We may not remove the other parent/guardian from the Emergency Contact List if there are no court documents on file. *

Excused Absences

1. Best Interest of the Child/Vacation (**maximum of 10 days per year July 1-June 30**)
2. Court Ordered Visitation-court order NOT mediation plan must be on file and **must be approved prior to absence**
3. Health reasons, Illness or Quarantine- **ENROLLED child and/or parent/Guardian**

Best Interest of the Child

"Best Interest of the Child" absences include family vacation, non-court ordered time with parent, time with relatives, family friends, religious or cultural events or family celebrations, family emergency. A best interest of the child absence is considered excused when the parent has notified the center in advance that the child will be absent. Vacation is included in the **ten total (10)** best interest days per year (July 1-June 30).

Court Ordered Visitation

Court ordered visitation is only excusable in the event that the court has issued a judgment/court order declaring when the child will visit the other parent. The court order must be on file. A mediation agreement is not a court order.

Health/Illness/Quarantine

Your enrolled child may be excused from school due to health, illness or quarantine of the enrolled child or parent/guardian. For example, if a sibling is sick, the enrolled child may not have an excused absence.

If your child is sick with the following symptoms, we ask that you please keep them home: fever of 100° degrees or more; nausea; vomiting or severe stomach pain; diarrhea; frequent, loose or watery stools; sore throat; acute cold or persistent cough; earache; red, inflamed or infected eye(s); swollen glands

Note to Agency Staff: Please give parent original and keep a copy in the child's file.

ATTENDANCE/DROP-OFF/PICK-UP POLICY

around the jaws, eyes or neck; live head or body lice; skin lesion in the weeping stage; and any other symptoms suggesting acute illness.

If your child's absence is due to communicable illness, written documentation from the child's doctor will be requested stating that the child may return to school.

Unexcused Absences

Any absence other than those described above as "excused absences" are considered unexcused. If a child has more than **five (5) unexcused absences** in a year (July 1 – June 30), services will be terminated or transferred to a Home Base program option. F*or CCTR/EHS Fee Paying Families*, fees will be charged for all unexcused absences.

Parental Acknowledgement

_____ **I acknowledge** that daily attendance is important for young children to learn daily routines, make friends, and develop skills that will help them succeed in school and throughout their lives.

_____ **I acknowledge** that by signing this form I am aware that I am enrolling my child in a dually-funded (State and Federal) child care and education program and that if my child will not be in attendance I must contact the site within one (1) hour of their scheduled drop-off time.

_____ **I acknowledge** that I **MAY NOT** remove a parent from the Emergency Contact list unless I present a current court order that prohibits that person from picking up the child.

_____ **I acknowledge** that employees of NHA will not release my child to me if I arrive under the influence of alcohol or other substances (including recreational drugs). We will make every attempt to reach an alternate contact listed on the Emergency Card. If no one is available, we may not release your child to you and will contact the police.

_____ **I acknowledge** that staff have the right to determine when an excused absence becomes un-excused, based on the individual circumstances and have the right to determine when my child's absences become excessive. Excessive absences may result in an Attendance Success Letter or Plan to help support regular attendance for my child.

_____ **I acknowledge** that shall my child exceed the allotted number of absences; ***my child will be terminated from service***. If possible, my child may be transferred to a Home Base option.

- Best Interest of the Child/Vacation (**maximum of 10 days per year July 1-June 30**)
- Unexcused (**maximum of 5 days per year July 1-June 30**)

_____**I acknowledge** ***(Fee Paying Families ONLY)*** that a fee (*if applicable*) will be charged for all absences with no adjustments.

For additional information, please refer to the Parent Handbook.

_____ _____

Child's Name Site/Room #

_____ _____

Parent Signature Date

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) Health Condition: ☐ Epilepsy ☐ Diabetes ☐ Severe Asthma ☐ Feeding Tube ☐ Severe Allergies ☐ 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: _____ Services: (Indicate types and service length) : Part B/C Provider: Has Specialized Academic Instruction ☐ Yes ☐ No
B. Non-IEP/IFSP related Disability or Mental Health (Social-Emotional/Behavioral) Concern: *For example: Healthy Developmental Services, Rady Children's KidStart, PCIT, ABA, CWS involved, etc.* ☐ 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

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

NOTIFICACIÓN SOBRE LOS DERECHOS DE LOS PADRES EN RELACIÓN A LAS GUARDERÍAS INFANTILES

DERECHOS DE LOS PADRES

Como padre/madre/representante autorizado, usted tiene derecho a:

1. Entrar e inspeccionar la guardería infantil (llamada "guardería" de aquí en adelante) sin notificación previa, en cualquier momento en el cual los niños estén bajo cuidado.

2. Presentar una queja con la oficina de licenciamiento en contra de la persona con licencia y revisar el expediente público que la oficina de licenciamiento tenga de la persona con licencia.

3. Revisar, en la guardería, los reportes sobre las visitas a la guardería por parte de la oficina de licenciamiento y las quejas comprobadas en contra de la persona con licencia que se hayan presentado durante los últimos tres años.

4. Quejarse con la oficina de licenciamiento e inspeccionar la guardería sin que se discrimine ni que se tomen represalias en contra de usted ni de su hijo.

5. Pedir por escrito que no se le permita a un padre/madre que visite al niño de usted ni que se lo lleve de la guardería, siempre y cuando usted haya presentado una copia certificada de la orden de la corte.

6. Recibir de la persona con licencia el nombre, dirección y número de teléfono de la oficina local de licenciamiento.

   Nombre de la oficina de licenciamiento: _____

   Dirección de la oficina de licenciamiento: _____

   Número de teléfono de la oficina de licenciamiento: _____

7. Después de haberlo solicitado, que la persona con licencia le informe del nombre y tipo de asociación con la guardería de cualquier persona adulta a quien se le haya otorgado una exención en relación a sus antecedentes penales, y que el nombre de la persona también se puede obtener comunicándose con la oficina local de licenciamiento.

8. Recibir de la persona con licencia, el formulario sobre el proceso para la revisión de los antecedentes de los proveedores de cuidado.

NOTA: ***LA LEY ESTATAL DE CALIFORNIA ESTIPULA QUE LA PERSONA CON LICENCIA PUEDE NEGAR EL ACCESO A LA GUARDERÍA AL PADRE/MADRE/REPRESENTANTE AUTORIZADO SI SU COMPORTAMIENTO PONE EN RIESGO A LOS NIÑOS BAJO CUIDADO.***

Para ver la base de datos del Departamento de Justicia sobre los delincuentes sexuales inscritos (conocida en inglés como "Registered Sex Offender Database"), vaya a www.meganslaw.ca.gov

(Separe aquí. Dele esta porción a los padres.)

CONFIRMACIÓN DE HABER RECIBIDO LA NOTIFICACIÓN SOBRE LOS DERECHOS DE LOS PADRES

(Se requiere la firma del padre/madre/representante autorizado.)

Yo, el padre/madre/representante autorizado de _____, he recibido, de la persona con licencia, una copia de la "NOTIFICACIÓN SOBRE LOS DERECHOS DE LOS PADRES EN RELACIÓN A LAS GUARDERÍAS INFANTILES" y el formulario sobre el PROCESO PARA LA REVISIÓN DE LOS ANTECEDENTES DE LOS PROVEEDORES DE CUIDADO.

_____
Nombre de la guardería

_____ _____
Firma (Padre/madre/representante autorizado) Fecha

NOTA: ***Esta Confirmación se tiene que conservar en el expediente del niño y una copia de la Notificación se le tiene que dar al padre/madre/representante autorizado.***

Para ver la base de datos del Departamento de Justicia sobre los delincuentes sexuales inscritos (conocida en inglés como "Registered Sex Offender Database"), vaya a www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

DERECHOS PERSONALES

Guarderías infantiles

Derechos personales - Vea la Sección 101223 sobre las condiciones para exenciones en relación a las guarderías infantiles.

(a) Guarderías infantiles. Cada niño que reciba servicios de una guardería infantil tendrá derechos que incluyen pero que no se limitan a los siguientes:

(1) a ser tratado con dignidad en sus relaciones personales con el personal del establecimiento y con otras personas.

(2) a que se le proporcione alojamiento, muebles, y equipo que sean seguros, higiénicos, y cómodos, para satisfacer sus necesidades.

(3) a no recibir castigo corporal o poco común; a que no se le cause dolor o humillación; a que no se le intimide; a no recibir burlas, coerción, amenazas, abuso mental, u otros castigos incluyendo pero no limitándose a: interferir con las funciones diarias de la vida, tales como el comer, dormir, o usar el baño; a que no se le niegue alojamiento, ropa, medicamentos, o medios auxiliares para el funcionamiento físico.

(4) a que la persona con licencia para el cuidado de niños le informe al niño, así como a su representante autorizado si lo hay, sobre lo que dice la ley con respecto a las quejas. Esta información debe incluir pero no limitarse a la dirección y número de teléfono de la sección en la oficina de licenciamiento que recibe quejas, e información con respecto a la confidencialidad.

(5) a tener la libertad de asistir a los servicios o a las actividades religiosas que desee, y a recibir visitas del consejero espiritual que prefiera. La asistencia a los servicios religiosos, ya sea dentro o fuera del establecimiento, deberá ser completamente voluntaria. En las guarderías infantiles, los padres o tutores legales del niño deberán tomar las decisiones sobre la asistencia a servicios religiosos y las visitas de consejeros espirituales.

(6) a que no se le encierre con llave en ninguna habitación, edificio, ni parte del establecimiento durante el día o la noche.

(7) a que no se le coloque en ningún aparato para limitar sus movimientos, excepto en un aparato de restricción para proporcionar apoyo que haya sido aprobado desde antes por la oficina de licenciamiento.

EL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL TIENE EL DERECHO A QUE SE LE INFORME SOBRE LA OFICINA DE LICENCIAMIENTO APROPIADA CON LA CUAL DEBE COMUNICARSE SI TIENE QUEJAS. LA OFICINA ES:

NOMBRE

DIRECCIÓN

CIUDAD	CÓDIGO POSTAL	AREA/NÚMERO DE TELÉFONO

SEPARE AQUÍ

AL: PADRE/MADRE/TUTOR LEGAL/NIÑO O REPRESENTANTE AUTORIZADO:

PARA EL EXPEDIENTE DEL NIÑO

Complete la siguiente confirmación, una vez que se le haya dado la información respecto a los derechos personales de una manera satisfactoria y completa, según se explica aquí:

CONFIRMACIÓN: Se me (nos) informó personalmente y recibí una copia de los derechos personales que contiene el Título 22 del Código de Ordenamientos de California, en el momento de admisión a:

(ESCRIBA CON LETRA DE MOLDE EL NOMBRE DEL ESTABLECIMIENTO)	(ESCRIBA CON LETRA DE MOLDE LA DIRECCIÓN DEL ESTABLECIMIENTO)

(ESCRIBA CON LETRA DE MOLDE EL NOMBRE DEL NIÑO)

(FIRMA DEL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL)

(TÍTULO/PUESTO DEL REPRESENTANTE/PADRE/MADRE/TUTOR LEGAL)	(FECHA)

CALIFORNIA PRE-KINDERGARTEN AND SCHOOL IMMUNIZATION RECORD

Pre-kindergarten facility and school staff must record the required vaccine dose information and status of requirements for each pupil. *See reverse side for guidance.*

PUPIL NAME (LAST, FIRST, MIDDLE)	STATEWIDE STUDENT IDENTIFIER (SSID)	ETHNICITY	RACE
	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other _____
NAME OF PARENT/GUARDIAN (LAST, FIRST)	BIRTHDATE (MONTH/DAY/YEAR)	SEX	
	___ ___ ___ ___ ___ ___ ___ ___	_____	

REQUIRED VACCINE	DATE EACH DOSE WAS GIVEN (MM/DD/YY)					Permanent Medical Exemption	Notes for School Requirements
	1ST	2ND	3RD	4TH	5TH		
IPV / OPV (Polio)			Age:_____ years			☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTaP / DTP – Age 0-6 years **Tdap / Td –** Age 7+ years (Diphtheria, Tetanus, Pertussis)			Age:_____ years	Age:_____ years		☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7th Grade requirement.
MMR (Measles, Mumps, Rubella)	Age:_____ months					☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
Hib (*Haemophilus influenzae* type b)						☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
Hep B (Hepatitis B)						☐	3 doses meet TK/K-12 requirement.
VAR / VZV (Varicella or Chickenpox)						☐	2 doses meet TK/K-12 requirement.
Tdap – 7th Grade (Tetanus, Diphtheria, Pertussis)	Age:_____ years					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7th-12th grade admission.

STATUS OF REQUIREMENTS	Staff Initials *I reviewed pupil's Immunization record*	Has All Required Vaccine Doses	Requires Follow-up			Follow-up Date(s) (See conditional admission schedule or exemption end date)	Other *See codes on reverse side*	Date Requirements Met
			Temporary Medical Exemption	Missing Doses Not Currently Due—Conditional	Missing Doses Are Overdue—Needs Doses Now			
Pre-Kindergarten (Child care or preschool)		☐	☐	☐	☐		☐ IEP ☐ PBE (pre-2016)	
TK/K-12		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home ☐ PBE (pre-2016)	
7th Grade (Advancement or admission)		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	

GUIDANCE FOR COMPLETING FORM CDPH 286

Review the pupil's immunization record for admission to:

- Pre-kindergarten (child care or preschool);
- Transitional kindergarten/kindergarten through 12th grade (TK/K-12);
- (Or advancement to) 7th grade.

1. Complete the pupil's identification section. The Statewide Student Identifier (SSID) is a 10-digit number assigned to TK/K-12 public school pupils by the California Department of Education.

2. Complete the vaccine and dose section using information from the pupil's immunization record provided by a parent or guardian, prior school, or an immunization registry.

    a. Record the date (month/day/year) of each dose the pupil has received, even if the pupil has an exemption to one or more required vaccines. Any vaccine given four or fewer days prior to the minimum required age is valid.
    b. Check the Permanent Medical Exemption (PME) box(es) for vaccines that are permanently exempt for medical reasons. If all vaccines are exempted, then fill in the date for "Date Requirements Met" in the appropriate row in the Status of Requirements section. This date is usually the date records are determined to be complete. File the required physician's written statement specifying the exempted immunization(s) in the pupil's record.

3. Complete the appropriate row in the Status of Requirements section.

    a. Enter the initials of the staff reviewing the pupil's record.
    b. If the pupil meets admission requirements, check the designated box and enter the date under "Date Requirements Met." This date is usually the date records are determined to be complete.
    c. If the pupil does not have all required doses but is not due for any doses at the time of admission, check the "Missing Doses Not Currently Due–Conditional" box and fill in the "Follow-up Date(s)" space. Review records at least every 30 days. Once the pupil meets all admission requirements, fill in the date for "Date Requirements Met."
    d. If the pupil has a Temporary Medical Exemption, check the designated box and write the expiration date in the "Follow-up Date(s)" space. Once the pupil meets all admission requirements, fill in the date for the "Date Requirements Met."
    e. If the pupil is due for doses and subject to exclusion, check the "Missing Doses Are Overdue–Needs Doses Now" box and fill in the "Follow-up Date(s)" space.
    f. If the pupil does not have all required immunizations and does not meet criteria for conditional admission (including a temporary medical exemption) and is:
        - **IEP:** Accessing special education services required by the pupil's individualized education program, or
        - **IND:** Enrolled in an independent study program and does not receive classroom-based instruction, or
        - **Home:** Enrolled in a home-based private school, or
        - **PBE (pre-2016):** Transferring from another school in California with a valid personal beliefs exemption filed before 2016,

        Then, using the codes above, check the appropriate box under "Other" and fill in the date for "Date Requirements Met."

Maintain a roster of all pupils who are unimmunized for immediate identification in case of disease outbreak or exposure in the community.

TRANSFER PUPILS

Transferring from a school in-state or another state: Review the immunization information and supporting documentation for exemptions included in the pupil's record or other immunization record, verifying the pupil has met immunization requirements for the pupil's age/grade. If the pupil has a personal beliefs exemption (PBE) filed in California prior to 2016 and has not reached the next grade span (in accordance with Health and Safety Code section 120335) or has a Permanent Medical Exemption (PME), then add the pupil's name to your facility's roster of unimmunized pupils.

Transferring from your school: Provide this form or an equivalent immunization record as specified in 17 CCR section 6070(b) and any exemption documentation as part of the pupil's record.

If a pupil transfers from one school to another within California, the pupil's record shall be transferred by the former school no later than 10 school days following the date of request from the school where the pupil intends to enroll (California Education Code section 49068).

Foster children: California law requires schools to immediately enroll foster children transferring to their school even if the child is unable to produce immunization records normally required for school entry. Within two business days of the foster child's request for enrollment, the educational liaison for the new school shall contact the school last attended to obtain all records. The educational liaison for the school last attended shall provide all records to the new school within two business days of receiving the request (California Education Code section 48853.5(e)(8)(C)).

HEALTH CONSENT AND ACKNOWLEDGEMENT FORM

Child's Name:_____ Date of Birth: ____ / ____ /_____

Your child may be eligible to receive hearing, vision, blood pressure, growth measurements, and developmental screenings through Head Start and/or collaborative partners. There is no cost for these services and you will be notified of the results. Some of these screenings will be done by trained staff at your child's site.

AGE	SCREENINGS: Please indicate whether you would like your child to receive the following by initialing the boxes in the "Initials" column to the right.	INITIALS
0-3 yrs.	**(Early Head Start Only)** I am aware that my child is required to have a complete well baby check-up/physical exam to include an oral visual exam as required by California State Guidelines for regularly scheduled visits. A complete **dental examination is required at 12 months**.	
0-5 yrs.	I have received information on the Health Handbook resource.	
0-5 yrs.	I grant permission for my child to have **ONGOING DEVELOPMENTAL ASSESSMENTS, ASQ-3 DEVELOPMENTAL SCREENING as well as an ASQ-SE MENTAL HEALTH SCREENING.** These screenings/assessments evaluate your child's development in speech and communication, fine motor skills, gross motor skills, social and emotional skills, and problem-solving skills. These screenings will help site staff provide support for your child.	
0-5 yrs.	I grant permission for staff to provide **social, emotional and behavioral consultation services** for my child as needed. These services support teachers and families to promote a child's social and emotional well-being.	
1-5 yrs.	I grant permission for my child to participate in the fluoride program **(daily brushing with fluoride toothpaste)**. Regular tooth brushing helps to prevent cavities and gum disease.	
0 m-5 yrs.	I grant staff permission to perform the following health screening on my child: **HEIGHT AND WEIGHT**.	
3-5 yrs.	I grant permission for my child to have a **VISION** screening. Vision screenings will be conducted by Head Start and/or collaborative partners. If your child needs glasses, glasses will be provided to your child free of charge.	
0-5 yrs.	I grant permission for my child to have a **HEARING** screening. Hearing screenings will be provided by Head Start and/or collaborative partners.	
3-5 yrs.	I grant staff permission to perform the following health screening on my child: **BLOOD PRESSURE**.	
3-5 yrs.	I am aware that my child is required to have a complete **PHYSICAL** and **DENTAL EXAMINATION** annually. I will be responsible to ensure that all treatment and follow-up is completed.	

Comments:

_____

_____

I have read and understand the above information. Date: _____

Parent Name (print) _____ Parent Signature _____

CHILD'S PRE ADMISSION HE ALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
■ Chicken Pox		■ Diabetes		■ Poliomyelitis	
■ Asthma		■ Epilepsy		■ Ten-Day Measles (Rubeola)	
■ Rheumatic Fever		■ Whooping cough		■ Three-Day Measles (Rubella)	
■ Hay Fever		■ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ■ YES ■ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST	WHAT ARE USUAL EATING HOURS?
LUNCH	BREAKFAST _____
DINNER	LUNCH _____
	DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ■ YES ■ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ■ YES ■ NO	WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ■ YES ■ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ■ YES ■ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ■ YES ■ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ■ YES ■ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

EARLY HEAD START WELL BABY CHECKUP
1 MONTH

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ TB Risk Assessment
  - □ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - □ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____

DEVELOPMENTAL MILESTONES

- ❑ Shows better head control
- ❑ Lifts his/her head when lying on tummy
- ❑ Grasps your finger
- ❑ Stares at faces briefly
- ❑ Becomes quiet when others speak
- ❑ Different cries to indicate need
- ❑ Calms when swaddled and rocked

NUTRITION ASSESSMENT

Breast Milk: □ Yes □ No Formula: □ Yes □ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Regular bowel movements: □ Yes □ No: _____

Feeding issues: □ No □ Yes: _____

IMMUNIZATIONS RECEIVED

- ❑ Polio 1 _____/_____/_____
- ❑ DTP 1 _____/_____/_____
- ❑ Hib 1 _____/_____/_____
- ❑ Hep B 1 _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Burns, hot water temp 120° f
- ❑ Smoke detectors
- ❑ Immunizations risks
- ❑ Falls
- ❑ Second hand smoke

COMMENTS/CONCERNS:

2 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

EARLY HEAD START WELL BABY CHECKUP
2 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ TB Risk Assessment
  - □ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - □ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____

DEVELOPMENTAL MILESTONES

- ❑ Social smile (responsive)
- ❑ Follows past midline
- ❑ Follows parent with eyes
- ❑ Head raised to 45° when prone
- ❑ Grasps fingers
- ❑ Vocalizes

NUTRITION ASSESSMENT

Breast Milk: □ Yes □ No Formula: □ Yes □ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Regular bowel movements: □ Yes □ No: _____

Feeding issues: □ No □ Yes: _____

IMMUNIZATIONS RECEIVED

- ❑ Polio 1 _____/_____/_____
- ❑ DTP 1 _____/_____/_____
- ❑ Hib 1 _____/_____/_____
- ❑ Hep B 1 _____/_____/_____
- ❑ Other: _____ _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Burns, hot water temp 120° f
- ❑ Smoke detectors
- ❑ Immunizations risks
- ❑ Falls
- ❑ Second hand smoke

COMMENTS/CONCERNS:

4 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

EARLY HEAD START WELL BABY CHECKUP
4 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____
- ❑ Anemia Risk Assessment

  1. Do you ever struggle to put food on the table?

  ☐ *No* ☐ ***Yes*** ***- If Yes, Hgb/Hct test is required***

  2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?

  ☐ *Yes* ☐ ***No*** ***- If No, Hgb/Hct test is required***

  Anemia Risk Factors present

  ☐ Hgb/Hct Test Results: _____

  *Date: __ /__ /__ *(If different from exam date)*

DEVELOPMENTAL MILESTONES

- ❑ Coos, laughs aloud
- ❑ Brings hands together, toys to mouth
- ❑ Follows 180 degrees
- ❑ Sits with head steady when held
- ❑ Rolls over one way

NUTRITION ASSESSMENT

Breast Milk: ☐ Yes ☐ No Formula: ☐ Yes ☐ No
Ounces/feeding: _____
Feedings/24 hrs: _____
Juice: ☐ No ☐ Yes: _____
Regular bowel movements:
☐ Yes ☐ No: _____
Feeding issues: ☐ No ☐ Yes: _____
Solid foods: ☐ No ☐ Yes: _____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Choking hazards– appropriate foods
- ❑ Small objects out of reach
- ❑ Burns – hot liquids
- ❑ Second hand smoke

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 _____/_____/_____
- ❑ DTP 1 2 _____/_____/_____
- ❑ Hib 1 2 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ Other:_____ _____/_____/_____

COMMENTS/CONCERNS:

6 MONTH APPOINTMENT SCHEDULED:
_____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

EARLY HEAD START WELL BABY CHECKUP
6 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ Lead Risk Assessment
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____

DEVELOPMENTAL MILESTONES

- ❑ "Talks" to toys
- ❑ Turns to vocalized sounds
- ❑ Reaches for objects
- ❑ Transfers objects from hand to hand
- ❑ Sits briefly, leaning forward
- ❑ Rolls over two ways

NUTRITION ASSESSMENT

Breast Milk: ☐ Yes ☐ No Formula: ☐ Yes ☐ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Juice: ☐ No ☐ Yes: _____

Regular bowel movements: ☐ Yes ☐ No: _____

Feeding issues: ☐ No ☐ Yes: _____

Solid foods: ☐ No ☐ Yes: _____

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hib 1 2 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ Other:_____ _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Falls – stairs / gates, walkers, furniture
- ❑ Burns – hot surfaces & liquids, kitchen safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins safety sheet given
- ❑ Second hand smoke

COMMENTS/CONCERNS:

9 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

EARLY HEAD START WELL BABY CHECKUP
9 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ Lead Risk Assessment
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____
  Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____

DEVELOPMENTAL MILESTONES

- ❑ Sits without support
- ❑ Attempts to crawl
- ❑ Pulls to stand, cruises
- ❑ Transfers objects from hand to hand
- ❑ Uses pincer grasp
- ❑ Understands his or her name, "no" and "bye-bye"
- ❑ Babbles
- ❑ Fears strangers
- ❑ Waves, claps and copies others
- ❑ Enjoys peek-a-boo

NUTRITION ASSESSMENT

Breast Milk: □ Yes □ No Formula: □ Yes □ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Juice: □ No □ Yes: _____

Regular bowel movements: □ Yes □ No _____

Feeding issues: □ No □ Yes: _____

Solid foods: □ No □ Yes: _____

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hib 1 2 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ Other:_____ _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Falls – stairs / gates, walkers, furniture
- ❑ Burns – kitchen safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins safety sheet given
- ❑ Second hand smoke

COMMENTS/CONCERNS:

12 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

EARLY HEAD START WELL BABY CHECKUP
12 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____
- ❑ Blood Lead Test (Result Value: _____)
- ❑ Hgb/Hct (required at 12 months)
  - ❑ Test Results: _____

  *Date: __ /__ /__ *(If different from exam date)*

DEVELOPMENTAL MILESTONES

- ❑ Babbles, jabbers
- ❑ Mama & dada specific
- ❑ Neat pincer grasp
- ❑ Bye-bye, pat-a-cake, peek-a-boo
- ❑ Sits alone
- ❑ Crawls on hands & knees
- ❑ Pulls to stand, cruises

NUTRITION ASSESSMENT

Breast Milk: ☐ Yes ☐ No Formula: ☐ Yes ☐ No

Milk: ☐ No ☐ Yes: Type:_____

Ounces/feeding: _____ Feedings/24 hrs: _____

Wean to a cup: ☐ Yes ☐ No

Juice: ☐ No ☐ Yes: _____

Regular bowel movements: ☐ Yes ☐ No _____

Feeding issues: ☐ No ☐ Yes: _____

Solid foods: ☐ No ☐ Yes: _____

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 3 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ *MMR 1 _____/_____/_____
- ❑ *HIB booster _____/_____/_____
- ❑ Varicella ____/_____/_____

*(on or after 1st birthday regardless of any Hib doses given prior to 1st birthday)

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins
- ❑ Drowning / water safety
- ❑ Dental care – nursing / bottle carries
- ❑ Storage of firearms
- ❑ Second hand smoke

COMMENTS/CONCERNS:

15 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ _____ _____ / _____ / _____

Print Name of Doctor | Signature/ Official Stamped Signature | Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
(619) 531-5800 • FAX (619) 542-4186

WILMA J. WOOTEN, M.D.
PUBLIC HEALTH OFFICER

September 1, 2015

Dear Medical Provider:

LEAD TESTING AND SCREENING IN CHILDREN

The Childhood Lead Poisoning Prevention Program (CLPPP) of the County of San Diego Health and Human Services Agency strongly encourages physicians to provide lead screening testing to children presenting, who are attempting to enroll in Head Start. Head Start programs are required to ensure that all enrolled children between the ages of 12 months and 72 months of age receive a lead toxicity screening.

The requirements for a child enrolled in Head Start are:

- For a child enrolled before the age of 12 months, the program must obtain documentation that blood lead tests were conducted for the child at the ages of 12 *and* 24 months;
- If there is no documentation that a blood lead test was performed at 12 months, for a child enrolled between 12 and 24 months of age, a blood lead test must be performed as soon as possible. A second blood lead test will be required at 24 months of age;
- The program is required to obtain documentation that a blood lead test was performed at 24 months of age, or soon thereafter, for a child enrolled at age 24 months or older.

San Diego County ranks third in 2012 among California counties for having the highest number of lead poisoned children. Children living in San Diego County are particularly vulnerable because of the abundance of older housing stock and the proximity to the border where cultural traditions that may be associated with lead toxicity frequently accompany immigrant families into San Diego. Lead is a neurotoxin that is harmful to developing young children even at low levels and can cause irreversible damage to a developing brain and other body systems.

Please contact the Childhood Lead Poisoning Prevention Program at (619) 692-8487 for further information about testing, case management services, education and outreach, or to request educational materials.

Live Well!

WILMA J. WOOTEN, M.D., M.P.H.
Public Health Officer
Director, Public Health Services

WJW:

EARLY HEAD START WELL BABY CHECKUP
15 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ Lead Risk Assessment
- ❑ TB Risk Assessment
  - ☐ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - ☐ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____
- ❑ Blood Lead Test (Result Value: _____)
- ❑ Anemia Risk Assessment

  1. Do you ever struggle to put food on the table?
  ☐ *No* ☐ ***Yes - If Yes, Hgb/Hct test is required***

  2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
  ☐ *Yes* ☐ ***No - If No, Hgb/Hct test is required***
- ❑ Anemia Risk factors present
  - ☐ Hgb/Hct Test Results: _____

    *Date: __ /__ /__ *(If different from exam date)

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 3 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ *MMR 1 _____/_____/_____
- ❑ *HIB booster _____/_____/_____
- ❑ Varicella _____/_____/_____

*(on or after 1st birthday regardless of any Hib doses given prior to 1st birthday)

DEVELOPMENTAL MILESTONES

- ❑ Walks steadily
- ❑ Stoops to pick up objects and then keeps walking
- ❑ Crawls up stairs
- ❑ Tries to climb on objects
- ❑ Holds a cup well, starts to use a spoon
- ❑ Scribbles
- ❑ Says 3-6 words other than "mama" and "dada"
- ❑ Follows simple commands
- ❑ Points to things and body parts
- ❑ Recognizes own image in a mirror
- ❑ Likes looking at books
- ❑ Starts to say, "no," and may have tantrums

NUTRITION ASSESSMENT

☐ Breast ☐ Bottle ☐ Cup

☐ Milk: Type: _____ Ounces/day:_____

Juice: ☐ No ☐ Yes: _____

Regular bowel movements: ☐ Yes ☐ No _____

Feeding issues: ☐ No ☐ Yes: _____

Solid foods: ☐ No ☐ Yes: _____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins
- ❑ Drowning / water safety
- ❑ Dental care – nursing / bottle carries
- ❑ Storage of firearms
- ❑ Second hand smoke

COMMENTS/CONCERNS:

18 MONTH APPOINTMENT SCHEDULED:
_____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____

TODDLER PHYSICAL
18, 24, & 30 months

Child's Name: _____ DOB: ____ /____ /____ AGE: _____ yrs. _____ mos.

Site: _____ Phone: _____ Fax: _____ PID#_____

Weight:	Height:	Head Circumference: (18-23 months only)
Percentile:	Percentile:	Percentile:

GENERAL APPEARANCE

General:	☐ Well-nourished and developed
Head:	☐ Symmetrical A.F.: Open (_____ cm) OR Closed
Eyes:	☐ Appears to see ☐ No strabismus
Ears:	☐ Appears to hear
Nose:	☐ Passages patent
Mouth & pharynx:	☐ Normal color and without lesions
Teeth:	☐ Grossly normal
Neck:	☐ Supple, no masses palpated
Heart:	☐ No murmurs, regular rhythm
Lungs:	☐ Breath sounds normal bilaterally
Abdomen:	☐ Soft, no masses, liver & spleen not enlarged
Genitalia: male:	☐ Normal appearance: Circumcised Uncircumcised ☐ Testes in scrotum rt. Lt.
Female:	☐ No lesions, normal external appearance
Extremities:	☐ No deformities, full rom
Skin:	☐ Clear, no significant lesions
Neurologic:	☐ Alter, moves extremities well

ANTICIPATORY GUIDANCE ☐ Yes ☐ No

NUTRITION/PRESCRIPTION RECOMMENDATIONS:

ABNORMAL FINDINGS AND/OR DIAGNOSIS:

NEXT APPOINTMENT SCHEDULED:
_____ /_____ /_____

IMMUNIZATIONS RECEIVED TODAY

☐ DTaP ☐ DT ☐ HIB ☐ Hep B
☐ TOPV ☐ IPV ☐ MMR ☐ VARICELLA

NUTRITION

Breast milk ☐ yes ☐ no
Formula ☐ yes ☐ no
_____ oz./feeding,
_____ feedings/24 hours
Solids: _____

❑ Normal bowel pattern
❑ Normal sleep habits
❑ Vitamins/fluoride

HISTORY

Drug allergy: ☐ Yes ☐ No
Passive smoking: ☐ Yes ☐ No

SCREENINGS COMPLETED DURING THE VISIT

☐ **TB Risk Assessment Completed**
Risk Factors not present; TB Skin Test not required
☐ **TB Risk Factors present (Test #1 or 2 Completed):**
Date test given: _____
1. ☐ Skin Test Date read Skin Test: _____
Results (skin) _____ mm
Interpretation: ☐ Negative ☐ Positive
2. ☐ Blood Test (IGRAs): ☐ Negative ☐ Positive
Chest X-Ray *(If Positive Test for #1 or 2):*
Date: _____ ☐ Normal ☐ Abnormal

☐ **Lead Test Results:**
12 m Result Value: _____ Date: _____
24 m Result Value: _____ Date: _____

☐ **Anemia Risk Assessment Completed:**
1. Do you ever struggle to put food on the table?
☐ No ☐ **Yes - *If Yes, Hgb/Hct test is required***
2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
☐ Yes ☐ **No - *If No, Hgb/Hct test is required***

☐ **Anemia Risk factors present:**
Hgb/Hct Test Results: _____
*Date: __ /__ /__ *(If different from exam date)

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

____ / ____ / ____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only
Date Received:
____ / ____ / ____

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Wilma J. Wooten, M.D.

WILMA J. WOOTEN, M.D., M.P.H.
Public Health Officer
Director, Public Health Services

WJW:

Dental Health Form

Patient Information (To be completed by Head Start staff)

Child's name	Date of Birth	FID#
Site Name	**Phone**	**Fax**

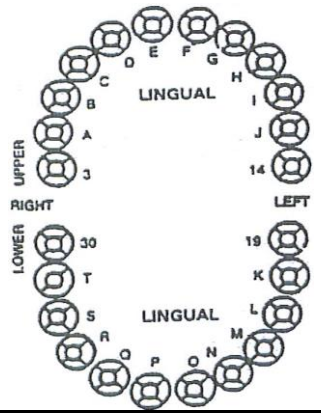
I. Oral Health Care Services Delivered During Visit (completed by Dental Professional)

Date of Exam _____ / _____ / _____ **AND/OR** **Date of Treatment** _____ / _____ / _____

Diagnostic/Preventive Services			Restorative/Emergency Care		
Examination:	☐ Yes	☐ No	Fillings	☐ Yes	☐ No
X-rays:	☐ Yes	☐ No	Crowns	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No	Extractions	☐ Yes	☐ No
Fluoride varnish:	☐ Yes	☐ No	Emergency Care	☐ Yes	☐ No
Dental sealants:	☐ Yes	☐ No	Other	☐ Yes	☐ No
Counseling/Anticipatory Guidance provided:	☐ Yes	☐ No	(specify:)		
Oral Hygiene Instructions provided:	☐ Yes	☐ No	**Comments:**		
All treatment completed: ☐ Yes ☐ No (***If "No", complete section II***)					

In diagram below Indicate oral condition before treatment

Missing Tooth Decayed Filled Cavities



II. Future Dental Treatment Needed (completed by Dental Professional)

Unable to proceed with treatment ☐ No ☐ Yes – **Specify:**

Child referred to Pedodontist/Specialist: ☐ No ☐ Yes – **Specify:**

Check the procedures needed:

☐ Fillings ☐ Crowns ☐ Extractions ☐ Emergency care

☐ Other **– Specify:**

More appointments needed for treatment: ☐ **Yes** ☐ **No**

If Yes: Approximate number of appointments needed: _____

Next appointment date: _____ / _____ / _____ Time: _____ : _____

If no treatment needed or treatment complete, Date of Next Recall: _____ / _____ / _____

III. Oral Health Provider's Contact Information and Signature/Official Stamped Signature

Print Name: _____ Phone: _____

Signature/Official Stamp: _____ Fax: _____

******** **Early Head Start / Head Start Staff Only** ******** **Date Received:** _____/_____/_____

INFANT NUTRITION/HEALTH QUESTIONNAIRE (0-12 months)

Center-Based: Complete a NEW FORM twice a year and review/update each form 3 months later. (Total of 4 meetings a year with parent)
Home-Based: Complete the questionnaire only when a child does not have a current Well-Baby Exam on file. Review/updates not required.

Child's Name: _____ **Date of Birth:** _____

DIETARY HABITS

1. Which of the following does your child drink?
   □ breast milk □ formula: _____ □ breast & bottle □ cow's milk □ soy milk □ almond milk
   □ other _____ (a) How much milk does your child drink each day and when? _____

2. Does your child have any food allergies or intolerances? □ no □ yes
   *If yes, submit a completed Request for Special Meals and/or Accommodations form to the Central Kitchen

3. Which foods do you give your child?

Ages 0-6 months: (see question 1)

Ages 6-8 months: □ rice cereal □ Iron-fortified cereal □ pureed fruits/vegetables □ pureed meats or beans

Ages 8-10 months: □ Iron-fortified cereal □ mashed fruits/vegetables □ teething crackers □ bread (small pieces)
□ eggs (well-cooked) □ pureed meats/beans □ dairy: soft cheese/yogurt □ none □ other:_____

Ages 10-12 months: □ Iron-fortified cereal □ cut up fruits/vegetables □ teething crackers □ bread (small pieces)
□ eggs (well-cooked) □ pureed meats/beans □ dairy: soft cheese/yogurt □ none □ other:_____

4. What is the consistency? □ puree □ strained □ diced/chopped □ finger food □ whole □ other: _____

5. When does your child eat and how much? (include times and amount served, like: 'a handful' or 'half of a small plate')
Does your child have any special feeding or meal time routines?

INDIVIDUAL DIAPERING PLAN

6. How often do you change your child's diaper? When does your child usually need a diaper change?

7. What concerns/instructions do you have about your child's daily diapering/toileting needs?

SLEEPING PATTERNS

8. When does your child usually sleep, and how long are they typically asleep for?

9. What helps your child to fall asleep?

SPECIAL NEEDS PLAN

10. Is your child under the care of a physician right now? □ no □ yes condition: _____
    *If yes, may require an IHP or Special Diet

11. Does your child have a diagnosed disability? □ no □ yes disability: _____

Additional comments/updates:

Initial Interview

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____

Review/Update 3 months later (Center-Based Only) □ no updates

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____

TODDLER NUTRITION/HEALTH QUESTIONNAIRE (13-36 months)

Center-Based: Complete a NEW FORM twice a year and review/update each form 3 months later. (Total of 4 meetings a year with parent)
Home-Based: Complete the questionnaire only when a child does not have a current Well-Baby Exam or Toddler Physical on file.

Child's Name: _____ **Date of Birth:** _____

DIETARY HABITS

1. Which of the following does your child drink?

□ breast milk □ formula □ breast & bottle □ cow's milk □ soy milk □ almond milk □ other _____

(a) How much milk does your child drink each day and when? _____

2. Does your child have any food allergies or intolerances? □ no □ yes
*If yes, submit a completed Request for Special Meals and/or Accommodations form to the Central Kitchen

3. Which foods do you give your child?
Ages 13-18 months: □ Iron-fortified cereal □ bread □ cut up fruits □ soft vegetables □ meats/protein: soft meat/beans □ dairy: milk/soft cheese/yogurt □ eggs (well-cooked) □ combo food (casseroles) □ none □ other:_____
Ages 19-36 months: □ cereal/oatmeal □ cracker/bread/tortilla □ fruits □ fruit juice □ vegetables □ meats/protein: nuts/seeds/beans □ dairy: milk/cheese/yogurt/whey protein powder □ eggs □ none □ other:_____

4. What is the consistency?
□ puree □ strained □ diced/chopped □ finger food □ whole □ other: _____

5. When does your child eat and how much? (include times and amount served, like: 'a handful' or 'half of a small plate')
Does your child have any special feeding or meal time routines?

6. What equipment can your child use?
□ Toddler cup □ regular cup □ spoon □ fork □ straw □ none

INDIVIDUAL DIAPERING/TOILETING PLAN

7. How does your child communicate that they need a diaper change or to use the potty?

8. What method(s) are you using to teach toileting skills to your child? □ N/A, child is potty trained

9. What concerns/instructions do you have about your child's daily diapering/toileting needs?

SPECIAL NEEDS PLAN

10. Is your child under the care of a physician right now? □ no □ yes condition: _____
*If yes, may require an IHP or Special Diet

11. Does your child have a diagnosed disability? □ no □ yes disability: _____

Additional comments/updates:

Initial Interview

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____

Review/Update 3 months later (Center-Based Only) □ no updates

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____

REQUEST FOR SPECIAL MEALS/ACCOMMODATIONS-MEDICAL STATEMENT

1. Print Name of Child	2. DOB	3. Site Name 4. EHS or HS / FD, PD AM or PM
5. Print Name of Parent/Guardian	6. Parent/Guardian Phone # ( )	7. Site Phone # ( )
8. Print Name of Supervisor	9. Print e-mail address of Site Supervisor @neighborhoodhouse.org	

10. Describe the child's physical or mental impairment affecting meals (i.e. "Allergy to peanuts"):

11. Explain the diet prescription/accommodation to ensure proper implementation.

12. Check box to indicate food texture for above child:

☐ Regular ☐ Chopped ☐ Ground ☐ Puréed

13. Foods to be omitted (i.e. AVOIDED) and the appropriate substitutions (i.e. Foods OK to eat):

Check the foods to OMITTED:

- ☐ fluid milk only
- ☐ cheese and yogurt
- ☐ foods containing dairy products (muffins, rolls)
- ☐ cooked eggs (scrambled, hardboiled)
- ☐ foods containing egg products (muffins)
- ☐ soy products
- ☐ nuts
- ☐ list other foods to AVOID:

_____

_____

Check the suggested substitutions:

- ☐ fluid milk only
- ☐ cheese and yogurt
- ☐ foods containing dairy products (muffins, rolls)
- ☐ cooked eggs (scrambled, hardboiled)
- ☐ foods containing egg products (muffins)
- ☐ soy products
- ☐ list other suggested food substitutions:

_____

_____

14. If applicable: List adaptive equipment to be used:

15. Signature of State Licensed Healthcare Professional*	16. Print Name	17. Phone Number ( )	18. Date / /

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

REQUEST FOR SPECIAL MEALS/ACCOMMODATIONS PARENT/GUARDIAN

1. Print Name of Child	2. DOB	3. Site Name 4. EHS or HS / FD, PD AM or PM
5. Print Name of Parent/Guardian	6. Parent/Guardian Phone #	7. Site Phone # ( )
8. Print Name of Supervisor	9. Print e-mail address of Site Supervisor @neighborhoodhouse.org	

PARENT/GUARDIAN REQUEST

COMPLETE THIS SECTION IF SPECIAL MEAL REQUEST IS FOR NON-MEDICAL REASON(S): MEDICAL AUTHORITY'S SIGNATURE IS NOT REQUIRED*
Please note: Our program may not be able to accommodate all requests

NHA's Nutrition Services Department does not serve pork or nuts

10. Write the reason for the alternative meal/milk option (example: child is vegetarian and does not eat meat):

11. Choose the alternative meal option:

☐ **Vegetarian =** no meat products, but all other food groups including DAIRY and EGGS will be served

☐ Eggs may be served ☐ Eggs need to be avoided

☐ **Fluid Milk Substitution =** due to dietary needs, a fluid milk alternative is requested **(SOY MILK ONLY)**
NOTE: For any other substitution request besides soy milk, a medical authority must complete the 2.8A.

PARENT/GUARDIAN MUST READ THIS STATEMENT: The above listed child does not have a disability, but the parent or legal guardian is requesting a fluid milk substitute due to a medical or other special dietary need. This form is not intended to accommodate children who drink fluid milk substitutions such as soy milk due to taste preferences. The child care agency has the discretion to select a specific brand of milk substitute since acceptable products must meet specified nutrient requirements. Juice cannot be offered as a fluid milk substitute for children with medical or special dietary needs that **do not** rise to the level of a disability. This written statement will remain in effect until the end of the current program year. Child care agencies participating in federal nutrition programs are encouraged, but not required, to accommodate reasonable requests. **The child's parent or legal guardian must sign this form.**

It may take at least 3 business days to process your above request, select an option to occur as it is processed:

12. ☐ **My child may attend and be offered the regular meals while my request is being processed.**
☐ **My child will not be attending until I am notified that my request is approved.**

13. Signature of Parent/Guardian*	14. Print Name	15. Date / /
16. Signature of NHA Staff	17. Print Name	18. Date / /

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at http://www.ascr.usda.gov/complaint_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: 202-690-7442 (3) E-mail: program.intake@usda.gov. This institution is an equal opportunity provider.

NHA MEDICATION INTAKE FORM

Child's Name: _____ DOB: _____ /_____ /_____ Date: _____ /_____ /_____

Name of Medication: _____ Medication Expiration Date: _____ /_____ /_____

This form must be completed for each medication that is brought to school.

- ✓ A staff member must complete this form before the child's first day of school.
- ✓ Medication cannot be accepted by the site until this form is completed.
- ✓ The Authorization to Administer Medication at school form must be completed and signed by the child's physician and parent/guardian.
- ✓ An IHP is required for all medications to be administered at school.

Accept medication ***ONLY*** if you can answer ***YES*** to all of the questions below.

1. Is the ***Authorization to Administer Medication at School form*** complete? *(Including: PARENT AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL)*	☐ Yes ☐ No
2. Are all required signatures completed on the ***Individual Health Plan (IHP)*** form?	☐ Yes ☐ No
3. Does the ***medication*** have the original label, and is it in the original box? *(For Over-the Counter Medications: add a label with child's name and date received to the medication, then check "Yes" for this item.)*	☐ Yes ☐ No
4. Is the child's ***name*** on the ***medication***? *(For Over-the Counter Medications: add a label with child's name and date received to the medication, then check "Yes" for this item.)*	☐ Yes ☐ No
5. Does the ***dosage*** and **name of medicine** match the medication information on the ***Authorization to Administer Medication at School form***? *(For Over-the-Counter Medications: refer to the Authorization to Administer Medication at School form for dosing instructions and check "Yes" for this item.)*	☐ Yes ☐ No
6. Is the ***medication*** current and ***not*** expired?	☐ Yes ☐ No

_____ _____ _____ /_____ /_____

Name of Staff *Signature of Staff* *Date*

Authorization to Administer Medication at School

Name of Child: _____ Date of Birth: _____

Site: _____ Phone: ( ) _____

MANDATORY: The PHYSICIAN must complete line items 1 - 8. (Missing items may affect child's program participation)

1) Please List Allergies and/or Medical Condition: _____

2) Medication **Generic** Name (No Brand Names)	**3)** When to take (i.e. Symptoms)	**4)** Dosage **AND** Frequency	**5)** Possible Side Effects **AND** Intervention Instructions

6) Begin Date of Medication: ____ / ____ / ____ **7)** End Date of Medication (**If applicable**): ____ / ____ / ____

8) Physician Signature/Date and Contact Information (or Official Stamp):

Name (print): _____

Signature: _____ Date: _____ / _____ / _____

Office phone #: (____) _____ Office Fax #: (____) _____

Physician/Clinic Address (print): _____

The following is to be completed by the PARENT after the above has been completed by the physician

PARENT AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

- ✓ I hereby authorize school staff to administer the inhaled and/or non-inhaled medication described above to my child.
- ✓ I understand that the teacher or school staff will administer only the medication described above.
- ✓ If the prescription is changed, a new form for parental consent with the physician's prescription and signature must be completed before any school staff will be able to administer the new medication.
- ✓ I also understand that the medication label and directions on the label must match the physician's prescription from this form.
- ✓ I understand that all medication must be delivered to the site in the original pharmacy container.

Print Name of Parent/Guardian: First _____ Last _____

Signature of Parent/Guardian _____ Date _____ /_____ /_____

Parent / Guardian Address: _____

Parent / Guardian Phone number _____

Individual Health Plan (IHP)

This form is valid until end of program year or child transfers to another school

Name of Child: _____ Date of Birth: _____

Site: _____ Date: _____

Parent/Guardian: _____ Phone: ( ) _____

DIAGNOSIS OF HEALTH CONDITION/AREA OF CONCERN: (ATTACH ANY DOCUMENTATION OF DIAGNOSIS)

☐ Heart Disease ☐ Asthma ☐ Seizure Disorder ☐ Kidney Disease ☐ Sickle Cell Disease

☐ Diabetes ☐ Other Medical Condition: _____

☐ Allergy - Name all known allergies:_____

MEDICATION(S) WILL BE TAKEN: ☐ **at School** (*If so, see Authorization to Administer Medication at School for instructions and possible side effects*) ☐ **Home only**

Name of medication(s) taken at home & possible side effects: _____

_____

CHECK ALL PROGRAM AREAS THAT NEED ADJUSTMENT TO ACCOMMODATE CHILD'S HEALTH CONDITION:

☐ Feeding ☐ Classroom Activities ☐ Toileting ☐ Outdoor Activities ☐ Transportation

☐ Other: _____

STAFF RESPONSIBLE:

☐ Site Supervisor:_____ ☐ Teacher: _____

☐ Assoc. Teacher: _____ ☐ Other: _____

I.) For Asthma or Any Condition Requiring Inhaled Medication ONLY ☐ **NOT APPLICABLE**

Check known triggers:

☐ tobacco ☐ pesticide ☐ animals ☐ cockroaches ☐ cleansers ☐ car exhaust

☐ perfume ☐ birds ☐ mold ☐ dust ☐ cold air ☐ exercise

☐ other: _____

Typical Signs and Symptoms of this child's asthma episodes (check all that apply)**:**

☐ Wheezing ☐ Persistent coughing ☐ Breathing faster ☐ Sucking in chest/neck ☐ Grunting

☐ Panting (flaring nostrils) ☐ Restlessness/Agitation ☐ Red, pale, or swollen face ☐ Fatigue

☐ Complaints of chest pain/tightness ☐ Dark circles under eyes ☐ Grey or blue lips or fingernails

Note to Staff: Notify parents immediately if emergency medication is required.

Get emergency help if:

- *The child does not improve 15 minutes after treatment and the family cannot be reached.*
- *After receiving treatment for wheezing, the child is working hard to breathe or is grunting, is breathing fast (greater than 50 breaths/minute), has trouble walking or talking, has sucking in of skin (chest or neck) with breathing, is extremely agitated or sleepy, has grey or blue lips or fingernails, has nostrils open wider than usual, won't play, cries more softly and briefly, and is hunched over to breathe.*

Staff use only: ☐ No Longer Applicable as of: Date: ___ / ___ / ___ Staff Initials: _____

Individual Health Plan (IHP)

This form is valid until end of program year or child transfers to another school

II.) For Severe Allergies Requiring Epipen or Epipen Jr. ONLY ☐ **NOT APPLICABLE**

Typical Signs and Symptoms of this child's anaphylaxis (check all that apply)**:**

Skin:	☐ Hives	☐ Itchy Rash	☐ Flushed or Pale Skin	
Throat:	☐ Constriction of Airways		☐ Swelling of Tongue or Lips	
Gut:	☐ Diarrhea	☐ Nausea	☐ Vomiting	
Lungs:	☐ Coughing	☐ Wheezing	☐ Trouble Breathing	☐ Cramps
Heart:	☐ Dizziness	☐ Fainting	☐ Weak Pulse	☐ Low Blood Pressure

Important Note to Staff:

- Act fast! Symptoms can change rapidly and can be life threatening!
- Do not depend on inhalers and/or antihistamines in an event of anaphylaxis.
- **Staff must call 911 and the parent/guardian immediately when epinephrine (Epipen/Epipen, Jr.) is administered.**

Staff use only: ☐ No Longer Applicable as of: Date: ___ / ___ / ___ Staff Initials: _____

III.) Other Health Condition(s) – *Name of condition(s)*: _____

Possible Symptoms Or Behaviors of Concern and Action to take Related To Child's Health Condition

Signs and Symptoms	Do the following:

Staff use only: ☐ No Longer Applicable as of: Date: ___ / ___ / ___ Staff Initials: _____

Staff Responsibilities: Site staff will monitor this child for the typical signs and symptoms of this child's health condition. Responsible staff will administer medication only as directed by the child's physician. Responsible staff will ensure that this child is not exposed to any known allergens. Responsible site staff will notify the parent/guardian of any concerns regarding this child's health while they are in school. Responsible site staff will notify the parent/guardian when medication is given.

Parent/Guardian Responsibilities: The parent/guardian will monitor this child for the typical signs and symptoms of this child's conditions at home and before they drop their child off at school. If this child is exhibiting any of the signs or symptoms of illness, the parent/guardian will keep the child at home. The parent/guardian will also inform site staff when medication has been given at home and if the child has been ill.

Individual Health Plan (IHP)

This form is valid until end of program year or child transfers to another school

STAFF TRAINED AND RESPONSIBLE TO ADMINISTER PROCEDURES AND ACCOMMODATIONS FOR THIS CHILD:
(***Requires at least 2 site staff trained on child's accommodations and procedure***)

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Training was done by: ☐ Parent/Guardian ☐ Other:_____
Indicate title or relationship to child

Print Name _____ Signature_____ Date: _____

NOTICE OF CHANGE IN STAFF

Note to staff: *This section is utilized* ***only*** *when a change in staff designated to administer required procedures has occurred.* Parent must be notified of change in staff providing accommodations for child.

STAFF TRAINED AND RESPONSIBLE TO ADMINISTER PROCEDURES AND ACCOMMODATIONS FOR THIS CHILD:
(Requires at least 2 site staff trained on child's accommodations and procedure)

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Training was done by: ☐ Parent/Guardian ☐ Other: _____
Indicate title or relationship to child

Print Name _____ Signature_____ Date: _____

Parent Consent for Application of Diaper Rash Cream or Sunscreen Medication at School

Site: _____ Date: _____

Name of Child: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: ( ) _____

I hereby authorize school staff to apply ☐ **diaper rash cream** and/or ☐ **sunscreen** to my child.

Product name: _____ Product Expiration Date: _____

I have used this product previously without any adverse reaction to my child's skin.

✓ Application begin date: _____ /_____ /_____ End date: _____ /_____ /_____

✓ List possible side effects of the diaper rash cream or sunscreen:

_____

✓ Parent Instructions for applying diaper rash cream or sunscreen:

Diaper Rash Cream: ☐ when rash is present ☐ with every diaper change

☐ other: _____

Sunscreen: ☐ before going outside ☐ other: _____

✓ For medical or other reasons, do not apply sunscreen to the following areas of my child's body:

_____

Print Name _____ Signature _____ Date: _____
Parent/Guardian

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

A new consent form is completed every school year or when product is changed.

Each application of diaper rash cream or sunscreen must be documented on the medication treatment log.

Parent Consent for Application of Diaper Rash Cream or Sunscreen Medication at School

NOTICE OF CHANGE IN STAFF

Name of Child: _____ Site: _____

STAFF RESPONSIBLE FOR APPLICATION OF DIAPER RASH CREAM OR SUNSCREEN ON THIS CHILD:
(Requires at least 2 site staff to be responsible)

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Print Name _____ Signature _____ Date: _____
Staff

Parent/guardian has been notified of change in staff for application of diaper rash cream or sunscreen on this child.

Print Name _____ Signature _____ Date: _____
Parent/Guardian

PARENT-HOME VISITOR AGREEMENT

Child Name: _____ DOB: _____

Welcome to the Early Head Start/Head Start Home-Based Program!

Home visits occur **once a week** in your home. Home visits are **90 minutes** in length.

Your home visits will occur on: _____.

Please let your Home Visitor know if you need to change the date/time of your weekly home visit. A new agreement form will be signed each time we adjust your designated date/time.

Socializations occur **twice a month** and provide an opportunity to interact with other children and families.

Home visits and socializations cannot be held with anyone besides the parent/guardian. Babysitters, friends or other relatives may attend the home visits and socializations, but they do not take the place of the parent/guardian.

The Home Visitor will:

- Conduct home visits and socializations. A monthly calendar will be provided of when these events will take place.
- Work together with you to plan activities for home visits and socializations.
- Coordinate services for your child and family, including education, family services, health, nutrition, mental health, and disabilities services as needed.
- Reschedule home visits if the child is exhibiting challenging behaviors and/or is uncooperative with parents' help.

The Parent/Guardian will:

- Actively participate in the entire home visit each week, provide input and help plan socializations, and attend socializations twice a month.
- Make sure that there are no distractions during the home visit (for example, turn off all televisions, radios, and/or cell phones).
- Keep pets in another room or outside.
- Work with the Home Visitor to develop home activities to do between home visits and talk about how things went during the next home visit.
- Implement positive parenting strategies if your child exhibits challenging behaviors during the home visit.
- Inform the Home Visitor if you or your child is ill. If there is a contagious disease in the home, the Home Visitor will conduct home visits once the illness has been resolved.

Cancellations and Rescheduling

If you need to cancel a home visit, you must contact the Home Visitor at least 24 hours before the scheduled home visit. Rescheduling of home visits is based on availability.

If three (3) consecutive home visits are missed or there are a total of four unexcused absences, then you will meet with the Home Visitor and Supervisor to discuss whether the Home-Based program is the best program option to meet your family's needs at this time.

☐ Parent received a copy of "A Parent's Guide to the Head Start Home-Based Program Option."
☐ Parent received a copy of the "Parent Pledge."
☐ Parent watched Home-Based program video on ECLKC (www.eclkc.acf.hhs.gov).

By signing this form, I acknowledge that I am in agreement with the expectations outlined above.

Parent/Guardian Signature: _____ Date: _____

Home Visitor Signature: _____ Date: _____

ACUERDO ENTRE LOS PADRES Y EL VISITANTE DEL HOGAR

Nombre del niño: _____ **Fecha de Nacimiento:**_____

¡Bienvenidos al Programa Basado en el Hogar de Early Head Start/Head Start!

Las visitas del hogar son programadas una vez por semana con una duración de 90 minutos (1½ hr.)

Sus visitas tomaran lugar el: _____.

Por favor informe al visitante del hogar si usted necesita cambiar la fecha/hora de su visita semanal. Se firmará un formulario nuevo del acuerdo cada vez que ajustemos su hora/fecha designada.

Las socializaciones ocurren **dos veces al mes** y ofrecen la oportunidad de interactuar con otros niños y familias.

Las visitas del hogar y socializaciones no se pueden llevar a cabo con nadie más que con el padre/tutor. Las niñeras, amigos, u otros parientes pueden asistir a las visitas del hogar o socializaciones, pero **no** pueden ser suplentes.

El Visitante del Hogar va a:

- Conducir las visitas del hogar y socializaciones. Le proporcionara un calendario mensual de cuando estos eventos tomaran lugar.
- Trabajar con usted para planear actividades para las visitas en el hogar y socializaciones.
- Coordinar servicios para su niño y familia, incluyendo educación, servicios familiares, salud, nutrición, salud mental, y necesidades especiales, como sean necesarios.
- Re-agendar la visita del hogar si el niño está exhibiendo un comportamiento desafiante y/o no coopera con la ayuda de los padres.

El Padre/Tutor va a:

- Participar de forma activa durante toda la visita de cada semana o el transcurso de toda la visita semanal, aportará y ayudará a planear las socializaciones; y asistirá a la socialización dos veces por mes.
- Asegurar que no exista ninguna distracción durante la sesión por ejemplo televisión, radio, teléfonos celulares.
- Mantener las mascotas en otra habitación o fuera de la casa.
- Trabajar con su visitante del hogar para desarrollar actividades a desempeñar en casa durante el periodo de ausencia entre cada visita, y platicar en la próxima visita de cómo le fue.
- Implementar estrategias positivas de crianza si su niño exhibe comportamientos desafiantes durante la visita.
- Informar a su visitante si su niño está enfermo. Si hay una enfermedad contagiosa en su hogar, el visitante continuara con sus visitas al hogar una vez que se haya contenido la enfermedad.

Cancelación y Reprogramación de visitas:
Si usted necesita cancelar o reprogramar una visita, usted necesita comunicarse con su visitante del hogar 24 horas antes de la visita programada. La reprogramación de la visita está basada en la disponibilidad del visitante.

Si falla a la visita domiciliaria 3 veces consecutivas o hay un total de 4 ausencias injustificadas, entonces tendrá que reunirse con la visitante de su hogar y supervisora para discutir si el Programa Basado en el Hogar es la opción del programa más adecuada para satisfacer las necesidades de su familia.

- ☐ El padre recibió una copia de "*Una guía para el padre de la opción del Programa Basado en el Hogar*"
- ☐ El padre recibió una copia del "*Compromiso de Padre*"
- ☐ Los padres de familia vieron en ECLK el video del Programa Basado en el Hogar

Al firmar este formulario, reconozco que estoy de acuerdo con las expectativas del Programa Basado en el Hogar que se han señalado anteriormente.

Firma del Padre/Tutor: _____Fecha_____

Firma del Visitante del Hogar: _____Fecha_____

AUTHORIZATION TO RELEASE INFORMATION
AUTORIZACIÓN DE PADRES PARA DIVULGAR INFORMACIÓN

Child / *Niño* _____ **Date of Birth** / *Fecha de Nacimiento* _____ **Center** / *Centro* _____

Parent / Guardian Name / *Padre / Tutor Nombre* _____ **Phone #** / *Teléfono #* _____ **Work #** / *Trabajo #* _____

Address / *Domicilio* _____ **Unit #** _____ **City** / *Ciudad* _____ **ZIP Code** / *Codigo Postal* _____

Requesting Records from:	**Record Requestor:**
_____ **Name of Releasing Doctor, Dentist or Agency** / *Nombre del Doctor, Dentista o Agencia que Proveerá la Información*	Neighborhood House Association (Early Head Start / Head Start) 5660 Copley Drive San Diego, CA 92111
_____ **Phone #** / *Teléfono #* _____ **Fax #** / *Numero de Fax*	_____ **Phone #** / *Teléfono #* _____ **Fax #** / *Numero de Fax*
_____ **Address** / *Domicilio*	

To release any / *Para dar cualquier información:*

☐ Medical / *Medica* ☐ Psychological / *Psicológica* ☐ Educational / *Educacional*

☐ Other records / *Otro:* _____
Specify Requested Record(s) / *Especificar Archivo(s) Solicitados*

Requested records will be used for the following purpose(s) /
La información se utilizara con el siguiente propósito:

☐ To individualize the program to meet the child's needs /
Individualizar los servicios para satisfacer las necesidades del niño

☐ To determine placement / *Determinar colocación*

☐ Other/*Otro:* _____

I consent to an exchange of information between these two agencies. I understand I will receive a copy of this consent upon request. I have the right to withdraw this authorization at any time. /
Yo doy mi consentimiento para intercambiar información entre estas dos agencias. Yo entiendo que recibiré una copia de este consentimiento a pedido. Tengo el derecho de retirar esta autorización en cualquier momento.

Parent/Guardian Signature / Padre/Tutor *Firma:* _____

Relationship to child / *Parentesco con el niño*: _____

Staff Signature / *Firma del Personal*: _____ **Date** / *Fecha*: _____ /_____/_____

Release of information is only valid for the current program year. /
Esta autorización es válida solo por el año actual del programa

INFORMACIÓN IMPORTANTE PARA PADRES

PROCESO PARA LA REVISIÓN DE LOS ANTECEDENTES DE LOS PROVEEDORES DE CUIDADO DEPARTAMENTO DE SERVICIOS SOCIALES DE CALIFORNIA

El Departamento de Servicios Sociales de California trabaja para proteger la seguridad de los niños bajo cuidado, proporcionando licencias a guarderías infantiles y hogares que proporcionan cuidado de niños. Nuestra mayor prioridad es asegurar que los niños estén en un ambiente de cuidado de niños que sea seguro y saludable. Las leyes de California requieren que se lleve a cabo una revisión de antecedentes para cualquier adulto que sea dueño de o que viva o trabaje en un hogar con licencia que proporciona cuidado de niños o en una guardería infantil con licencia. Cada uno de estos adultos tiene que presentar sus huellas dactilares para que se lleve a cabo una revisión de antecedentes para ver si tiene algún historial penal. Si determinamos que una persona ha sido condenada por un delito, que no sea una infracción menor de las reglas de tráfico o una ofensa relacionada con la mariguana la cual se trata bajo las nuevas leyes de reforma sobre mariguana de acuerdo a las Secciones 11361.5 y 11361.7 del Código de Salud y Seguridad, esa persona no podrá trabajar ni vivir en un hogar con licencia que proporciona cuidado de niños ni en una guardería infantil con licencia, a menos que lo apruebe el Departamento. A esta aprobación se le llama una exención.

Una persona que ha sido condenada por un delito como asesinato, violación, tortura, secuestro, delitos de violencia sexual o abuso sexual en contra de un niño, **por ley, no podrá recibir una exención que le permita ser dueño de o vivir o trabajar en** un hogar con licencia que proporciona cuidado de niños o en una guardería infantil con licencia. Si el delito fue un delito mayor *(felony)* o un delito menor grave, la persona tendrá que salir del establecimiento mientras que se revise la petición para una exención. Si el delito es menos grave, es posible que se le permita quedarse en el hogar con licencia que proporciona cuidado de niños o la guardería infantil con licencia mientras que se revise la petición.

Cómo se revisa la petición para una exención

Nosotros solicitamos información sobre los antecedentes de la persona a los departamentos de policía, la Oficina Federal de Investigaciones (FBI), y las cortes. Tomamos en consideración la clase de delito, cuántos delitos se han cometido, cuánto tiempo ha pasado desde que sucedió el delito, y si la persona ha sido honesta en lo que nos ha dicho.

La persona que necesita la exención tiene que proporcionar información sobre lo siguiente:

- el delito;
- lo que ha hecho para cambiar su vida y obedecer la ley;
- si está trabajando, asistiendo a la escuela, o recibiendo entrenamiento; y
- si ha completado de una manera satisfactoria algún programa de orientación o rehabilitación.

La persona también nos da cartas de referencia de otras personas que no tienen parentesco con él/ella y que tienen conocimiento del historial de él/ella y cómo es su vida ahora.

Nosotros revisamos todas estas cosas muy cuidadosamente al tomar una decisión sobre las exenciones. Por ley, no se puede compartir esta información con el público.

Cómo obtener más información

Como padre o representante autorizado de un niño bajo cuidado con licencia, usted tiene el derecho de preguntarle al hogar con licencia que proporciona cuidado de niños o a la guardería infantil con licencia si alguien que esté trabajando o viviendo allí tiene una exención. Si usted pide esta información y hay una persona con una exención, dicho hogar o guardería infantil tiene que decirle el nombre de la persona y la manera en que tal persona está involucrada en el hogar o guardería infantil. Además, tiene que darle el nombre, dirección, y número de teléfono de la oficina local de licenciamiento. Usted también puede obtener el nombre de la persona comunicándose con la oficina local de licenciamiento. Puede encontrar la dirección y el número de teléfono en nuestro sitio web. La dirección del sitio web es **http://ccld.ca.gov/contact.htm**

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm.**

PROGRESS NOTES

Child's Name:	Date of Birth:
Site/Classroom:	Teacher/Home Visitor:

☐ Enrollment ☐ Health/Nutrition ☐ Family Partnerships ☐ Education ☐ Disabilities ☐ Mental Health

DATE	RECORD YOUR CONTACT OR WORK DONE HERE	PRINT FIRST INITIAL AND LAST NAME

14. Los padres pueden aprender maneras de calmar a un bebé que llora y también controlar sus propios sentimientos de frustración cuando no pueden consolar al bebé.

15. Los padres pueden investigar a un proveedor de cuidado de niños para un historial de abuso de niños usando el Sistema del Registro de Personas con Antecedentes Aprobados para el Cuidado de Niños *(Trustline)*. Llame al 1-800-822-8490.

16. Los padres pueden pedir ayuda cuando se sienten estresados o deprimidos por los problemas de la vida.

17. Los padres que aprenden sobre la seguridad de los niños en el hogar pueden prevenir accidentes y aumentar la conciencia en cuanto al medio ambiente.

18. Los padres pueden utilizar servicios comunitarios tales como cuidado temporal de niños para ofrecer un descanso a los padres y servicios de visitas al hogar. Estos servicios pueden apoyar y fortalecer a los padres durante períodos difíciles.

19. Las comunidades pueden apoyar a las familias proporcionándoles actividades gratuitas o a bajo costo las cuales estimulan interacciones entre los padres y sus niños.

20. Redes comunitarias colaboran para facilitar que las familias reciban referencias y servicios.

STATE OF CALIFORNIA
(ESTADO DE CALIFORNIA)

HEALTH AND HUMAN SERVICES AGENCY
(SECRETARÍA DE SALUD Y SERVICIOS HUMANOS)

DEPARTMENT OF SOCIAL SERVICES
(DEPARTAMENTO DE SERVICIOS SOCIALES)

Office of Child Abuse Prevention
(Oficina para la Prevención del Abuso de Niños)

Pub 411 (SP) (8/11)

20 REALIDADES
ACERCA DEL
ABUSO Y DESCUIDO DE NIÑOS

1. El abuso o descuido de niños es un crimen.
2. Se puede tener acceso en el Internet a la Ley de California sobre el Deber de Reportar el Abuso y Descuido de Niños (Secciones 11164-11174.3 del Código Penal) en el sitio web: www.leginfo.ca.gov
3. El abuso y el descuido de niños afectan a los niños de todas las edades, razas, y niveles económicos.
4. Los casos en que se sospecha el abuso o descuido se deben reportar a la Oficina de Servicios para la Protección de Niños (CPS por sus siglas en inglés) o a la policía.
5. Una lista de los números de teléfono para las líneas de emergencia para reportar el abuso de niños en cada condado de California se encuentra en el sitio web: www.childsworld.ca.gov/res/pdf/CPSEmergNumbers.pdf
6. Los padres que abusan de las drogas o del alcohol corren más riesgo de abusar o descuidar a sus niños.
7. La exposición a la violencia doméstica afecta negativamente a los niños. La evidencia muestra que existe un fuerte vínculo entre la violencia doméstica y el abuso de niños.

8. Los niños que tienen menos de dos años de edad corren el mayor riesgo de sufrir abuso o descuido.
9. La prematuridad es un factor de riesgo para el abuso o descuido de niños.
10. El traumatismo craneoencefálico por maltrato o el síndrome del bebé que ha sido sacudido ocurre muchas veces cuando un adulto sacude a un niño debido al llanto inconsolable.
11. Los niños con discapacidades tienen más probabilidad de sufrir abuso o descuido que los niños que no tienen discapacidades.
12. Es posible que los niños que han sufrido descuido o abuso sexual no demuestren ninguna señal física de daño.
13. Los niños que viven en pobreza sufren descuido y abuso 22 veces más frecuentemente que los niños en familias de un alto nivel económico.
14. Es contra la ley hacer de manera intencional un reporte falso de abuso o descuido de niños.
15. El reportar un posible abuso o descuido de niños solamente requiere una "sospecha razonable" y no significa que automáticamente se vaya a sacar al niño del hogar.
16. Solamente una oficina de Servicios para la Protección de Niños o una oficina encargada de hacer cumplir la ley puede llevar a cabo una investigación acerca de una sospecha de abuso o descuido.
17. En California, se les requiere a las personas bajo mandato de reportar *(mandated reporters)* que reporten el abuso y descuido de niños. Las personas bajo mandato de reportar son aquellas personas que tienen contacto con los niños por medio de su empleo. Pueden recibir entrenamiento en: mandatedreporterca.com
18. Una vez que se hayan investigado los reportes de posible abuso de niños, estos reportes se clasifican como: comprobados, sin fundamento, o no concluyentes (sin evidencia suficiente).
19. Los reportes comprobados y los reportes no concluyentes de abuso o descuido de niños se incluyen en la base de datos de la Lista Central de Personas con Antecedentes de Abuso de Niños (CACI por sus siglas en inglés) del Departamento de Justicia de California.
20. Los reportes sin fundamento son excluidos de la base de datos de la CACI.

20 Maneras de Prevenir el Abuso y Descuido de Niños

1. La línea de emergencia conocida en inglés como *"Child Help USA Hotline"* ofrece ayuda por teléfono las 24 horas al día en casos de crisis a personas que están bajo estrés. Esta ayuda por teléfono está disponible en 140 idiomas al 1-800-422-4453.
2. Organizaciones tal como *"Parents Anonymous"* (Padres Anónimos) ofrecen sesiones en grupo para que los padres se ayuden unos a otros y compartan apoyo y estrategias positivas. Para información, vaya al sitio web: www.parentsanonymous.org
3. Consejos para la prevención del abuso de niños o centros de recursos para familias tienen recursos para ayudar a las familias. www.capsac.org/crisisnumbers/ca-councils o 222.familyresourcescenters.net
4. Los padres que piden ayuda para obtener vivienda, comida, transporte, y/o cuidado de la salud protegen a sus familias del estrés.
5. El mantener conexiones con familiares y amigos, compartiendo celebraciones así como problemas diarios, fortalece a las familias.
6. La familia que usa un médico familiar y un proveedor de cuidado de la salud promueve la buena salud y así les evalúan a los niños contínuamente para asegurar un desarrollo normal. Este tipo de familia se conoce en inglés como un *"medical home"*.
7. Los padres que animan y escuchan a sus niños aceptando la expresión de sus emociones les ayudan a desarrollar el amor propio saludable en cuanto a sí mismos y en relación a los otros.
8. Los padres que aprenden y usan metódos de disciplina seguros y no violentos se convierten en ejemplos positivos para sus niños.
9. El aprender lo que es normal en cuanto al desarrollo de sus niños les ayuda a los padres a aceptar a sus niños tal como son y disminuye la frustración de tener expectativas no realísticas.
10. Los padres que utilizan los programas de recuperación del abuso del alcohol o de las drogas aprenden cómo mantener la sobriedad y hacer conexiones con otras personas.
11. Hay clases para los padres que les enseñan los beneficios de establecer lazos con sus niños y comprender y aceptar las personalidades de sus niños.
12. Las preescolares de alta calidad les enseñan a los niños habilidades sociales y estimulan el desarrollo del amor propio.
13. El padre que hace una conexión con sus niños establece fuertes lazos familiares.

13. Fathers who connect with their children form strong family bonds.
14. Parents can learn ways to calm a crying baby and manage feelings of frustration when a baby is inconsolable.
15. Parents can investigate child care provider for any history of abusing children. Use Trustline to check out child care providers 800-822-8490.
16. Parents can ask for help when depressed or stressed by life's challenges.
17. Parents learning about child safety in the home can prevent accidents and increase awareness of the environment.
18. Parents can use community services such as respite care and home visiting services to strengthen parental resilience when times are tough.
19. Communities can support families by providing free or low-cost activities that encourage parent/child interactions.
20. Community networks collaborating with each other facilitate ease of referrals and obtaining services for families.

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

Office of Child Abuse Prevention

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20 Facts About Child Abuse and Neglect

1. Child abuse or neglect is a crime.
2. The California Child Abuse and Neglect Reporting Law (Penal Code sections 11164-11174.3) may be accessed on the internet at www.leginfo.ca.gov.
3. Child abuse and neglect affect children of all ages, races, and incomes.
4. Instances of suspected abuse or neglect should be reported to Child Protective Services (CPS) or police.
5. A listing of California's Hotline Numbers for child abuse reporting for each county may be found at www.childsworld.ca.gov/res/pdf/CPSEmergNumbers.pdf
6. Parents abusing drugs or alcohol are at higher risk of abusing or neglecting their children.
7. Exposure to domestic violence negatively impacts children. Evidence shows a strong connection between domestic violence and child abuse.

8. Children under two years of age are at greater risk of abuse or neglect.
9. Prematurity is a risk factor for child abuse or neglect.
10. Abusive head trauma or shaken baby syndrome often occurs when an adult shakes a child because of inconsolable crying.
11. Children with disabilities are more likely to be abused or neglected than children with no disabilities.
12. Neglected or sexually abused children may not show physical signs of harm.
13. Children in poverty suffer neglect and abuse 22 times more than children in affluent families.
14. It is against the law to knowingly make a false report of child abuse or neglect.
15. Reporting child abuse or neglect only requires "reasonable suspicion" and does not automatically mean the child will be removed from the home.
16. Only Child Protective Services or a law enforcement agency may conduct an investigation into suspected abuse or neglect.
17. In California, mandated reporters are required to report child abuse and neglect. Mandated reporters are those who come into contact with children through their employment and may receive training at mandatedreporterca.com.

18. Once investigated, reports of suspected child abuse are categorized as substantiated, unfounded or inconclusive (insufficient evidence).
19. Substantiated and inconclusive reports of child abuse or neglect are filed in the California Department of Justice Child Abuse Central Index (CACI) database.
20. Unfounded reports are purged from the CACI database.

20 Ways Of Preventing Child Abuse and Neglect

1. The Child Help USA Hotline offers 24-hour crisis telephone assistance for individuals under stress. Telephone counseling is available in 140 languages 800-422-4453.
2. Organizations such as Parents Anonymous offer self-help groups for parents seeking support and positive parent strategies at www.parentsanonymous.org.
3. Child Abuse Prevention Councils or Family Resource Centers have resources available locally to help families. www.capsac.org/crisisnumbers/ca-councils or 222.familyresourcescenters.net

4. Parents who ask for help in getting housing, food, transportation, and/or health care protect their families from stress.
5. Being connected to family and friends by sharing celebrations and day-to-day problems makes families stronger.
6. Families who use a family physician and healthcare provider, also known as a medical home, promote good health and children are screened for normal developmental milestones on an ongoing basis.
7. Parents who encourage, listen, and accept expression of emotions help their child to develop healthy self-esteem about themselves and in relation to others.
8. Parents who learn about and practice safe nonviolent forms of child discipline become positive role models for their children.
9. Learning what is normal with their child's development helps parents accept their child as they are and decreases frustration from unrealistic expectations.
10. Parents that utilize recovery programs for alcohol or drug abuse learn to stay clean and stay connected with others.
11. Parent education classes teach parents the benefits of bonding, understanding, and accepting their children's personalities.
12. High quality preschools teach children social skills and build self-esteem.