NEIGHBORHOOD HOUSE ASSOCIATION

Program Type: **Early Head Start - Services to Pregnant Women (SPW)**

☐ Pregnant ☐ Post-Partum

_____
Participant's Full Legal Name

_____
Child's Full Legal Name

FID #: _____
PID#: _____
Due Date: ____ / ____ / ____

Participant's Date of Birth ____ / ____ / ____

Child's Date of Birth ____ / ____ / ____

1st Day of Attendance/Services: ____ / ____ / ____

Drop Date **1.** ____ / ____ / ____

Transfer to EHS HB / FCC/Other **2.** ____ / ____ / ____

Address: _____

Apt. # _____
City: _____ **, CA**
ZIP Code: _____

Participant's Phone Numbers:
Home: _____
Work: _____
Cell: _____

0.0 SPW File Cover
Instruction Sheet

PURPOSE STATEMENT:

The purpose of the SPW File Cover Sheet is to provide basic information related to the client's current enrollment in the program.

TIMELINE:

To be completed at the time of enrollment or when there are changes to the family demographic information including the birth of the baby.

STAFF RESPONSIBLE:

The SPW File Cover Sheet is completed by the SPW Home Visitor or SPW Supervisor. Other staff may assist with the completion of this form should it be deemed necessary.

INSTRUCTIONS:

- Check off applicable program type: Pregnant or Post-Partum
- Complete all sections of the form completely as follows:
  - Client's Name - write the pregnant mother's name from PROMIS
  - Child's Name - write in child's name from PROMIS
  - Date of Birth – write in the DOB for the enrolled child
  - FID # - write in the Family Identification Number from PROMIS
  - PID # - write in the Personal Identification Number from PROMIS
  - Due Date- write the client's due date from the doctor
  - 1st Day of Attendance/Services– write in the actual first day of attendance (i.e. client's attendance at SPW lesson or date of first home visit)
  - Drop Date - write the drop date
  - Transfer to EHS HB/FCC/Other - write the date that the newborn is transferred to another program option
  - Write in all contact information for the client including address and phone numbers

EMERGENCY CONTACT INFORMATION

SPW Home Visitor Name: _____

SPW Participant's Full Legal Name: _____

Birth Date: _____ /_____ / _____ Due Date: _____ /_____ / _____ Most recent prenatal visit: _____/_____/_____

Next prenatal visit scheduled: _____/_____/_____

Address: _____ Home Phone: ( ) _____

_____ Work Phone: ( ) _____

Email address: _____

MEDICAL AND DENTAL INSURANCE

Physician: _____Medical Insurance: _____ ☐ No Insurance

Address: _____

Phone: ( ) _____ Hospital/Clinic: _____

Dentist: _____Dental Insurance: _____ ☐ No Insurance

Address: _____

Phone: ( ) _____ Office/Clinic: _____

SPW HEALTH INFORMATION - PLEASE CHECK THE FOLLOWING

Allergies: _____ ☐ N/A High Risk Pregnancy: ☐ Yes ☐ No

Participant has following medical conditions (if applicable):

_____

_____

PERSONS AUTHORIZED TO BE CONTACTED ON BEHALF OF SPW CLIENT IN CASE OF EMERGENCY

Name _____Phone ( ) _____Relationship _____

Name _____Phone ( ) _____Relationship _____

Name _____Phone ( ) _____Relationship _____

Print SPW Participant's Name: _____

SPW Participant's Signature: _____ Date: _____ /_____ /_____

Emergency Contact Information (SPW)
Instruction Sheet

PURPOSE STATEMENT:
The purpose of the form is to record the client's emergency contact information regarding allergies, medical/dental coverage, medical conditions, and persons authorized to contact in the event of an emergency.

TIMELINE:
Completed at the time of enrollment and updated as needed

STAFF RESPONSIBLE:
Services to Pregnant Women (SPW) Perinatal Home Visitor

INSTRUCTIONS:

- **General Information**: List the assigned Home Visitor's name, the SPW client's full name, due date, most recent prenatal visit, and next scheduled prenatal visit. Fill in the client's current contact information.

- **Medical and Dental Insurance:** List the type of medical and dental insurance. Write the Physician/Clinic and Dentist name, address, and phone number. If they are uninsured, check the box 'No Insurance' and provide a referral for medical and/or dental insurance. Enter the referral in PROMIS and update the Emergency Card once insurance is obtained.

- **SPW Health Information**: List any allergies. If none, mark 'N/A.' Mark whether it is a high risk pregnancy and if "yes," document the circumstances of the high risk pregnancy.

- **In Case of Emergency**: Have the client identify a minimum of three other responsible persons that can be contacted in case of an emergency. List their name, phone numbers, and relationship to the client.

- Have the client sign and date the completed form.

- Update the form and Intake tab of PROMIS if any changes to the form need to occur during the program year.

SECTION 1 - ENROLLMENT

SPW Table of Contents

- Progress Notes- Enrollment/Contact
- 1.1 Parent/ Perinatal/ Home Visitor Agreement
- 1.2 Document Receipt Acknowledgement
- 1.4 Pre-Enrollment Review for Children with Identified Health or Developmental Conditions **(if applicable)**
- 1.5A Pre-Enrollment Case Conference for Children with Identified Health and Nutrition Concerns **(if applicable)**
- 1.5B Pre-Enrollment Case Conference for Children with Identified Mental Health and Developmental Concerns **(if applicable)**
- 1.6 LIC 995 Parents Rights' (English or Spanish)
- 1.7 LIC 613A Personal Rights (English or Spanish)
- 1.9 Child File Transfer Form **(if applicable)**

1.2 Document Receipt Acknowledgement
Instruction Sheet

PURPOSE STATEMENT:

The Document of Receipt Acknowledgement is completed by Early Head Start/Head Start (EHS/HS) staff with the parent/guardian every year to document permission for recording and photographing children and that educational information and resources have been received by the parent/guardian.

TIMELINE:

Form is completed with parent at time of enrollment. If any information/resources are not provided at time of enrollment, the form must be completed when the parent does receive the necessary information/resources.

STAFF RESPONSIBLE:

Family Service Advocate, Home Visitor, EHS Teacher, Site Supervisor/Assistant Site Supervisor, Family Services Supervisor and other staff as assigned

INSTRUCTIONS:

Staff document child's name, date of birth, and site/program option.

PERMISSIONS:

- Staff reviews each of the audio/visual permissions with the parent.
    - #1 asks the parent to consent to have their child photographed or video/audio taped in the classroom, site or on parent engagement field days for educational use only. The images may be used in the child's portfolio, in the classroom or at the site.
    - #2 and #3 asks the parent to give permission for him/her and his/her child to be photographed or recorded by NHA for public or promotional use (ie. on the website, newsletters, social media, promotional videos, etc.).
        - **NOTE:** 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. If a child is foster/dependent of the County of San Diego, indicate in the Initials Box.
- If the parent gives permission, the parent checks the "I consent" box and initials. If the parent does not give permission, the parent checks the box "I don't consent" and initials.

1.2 Document Receipt Acknowledgement
Instruction Sheet

INFORMATION/RESOURCES PROVIDED:

- Staff provides the Information/Resources identified on the form and the parent/guardian initials that they have received the Information/Resource.
- If the parent does not receive an informational resource, leave the space blank. The resource shall be provided to the parent at a later date, and the parent will initial at that time. Staff should make every effort to have information/resources available at time of enrollment/re-enrollment.
- If the information/resource is not applicable to the parent/guardian, mark the box 'N/A.'

SIGNATURES:

Parent/guardian signs and dates the form indicating that s/he has read and understand the information on the form and information provided to them. Staff and signs and dates the form.

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: _____

1.4 Pre-Enrollment Review
Instruction Sheet

PURPOSE STATEMENT:

The purpose of the Pre-Enrollment Review (PER) is to assist in ensuring appropriate placement and support of all applicants with identified health, nutrition, documented mental health (behavioral and/or social-emotional), and/or disabilities (IEP/IFSP and non-IEP/IFSP) before they are enrolled.

TIMELINE:

The Pre-Enrollment Review is completed after a family submits an application and before a child is placed on the Prioritization List.

STAFF RESPONSIBLE:

The Family Service Advocate (FSA), Site or Home Base Supervisor, Family Services Supervisor (FSS), Early Head Start Program Assistant (EHS PA), or other designated staff completing the intake completes the family contact information, site, and date of application at the top of the form. This staff ensures necessary supporting documentation is collected and that the Authorization to Release Information form is completed and attached to the PER. The same staff member also completes the Health and Nutrition section of the PER as needed.

The PER form, Application, and supporting documentation is reviewed by the FSS or EHS PA and a Status Recommendation is marked and Service Requests (SR) are submitted to the appropriate staff.

The Area ECE/Disabilities Specialist (ECE) completes the developmental section as needed. The Comprehensive Services and Quality Improvement Program Support (CSQI PS) Disabilities Coordinator, Mental Health Coordinator, or Program Specialist may complete this section in the event of the ECE's absence.

INSTRUCTIONS:

The need for a PER form is determined at intake either by the staff completing the intake or by the FSS/EHS PA at the Area office. All children that have a disability, a health and/or nutrition condition, or a developmental or mental health concern noted on the Confidential Application for Child Development Services must have a PER form completed (for a full list of concerns/conditions that require a PER, please see the Health, Nutrition, Mental Health, and Disability CSQI PS Service Request Referral Criteria Standard Operating Policies and Procedures (Criteria SOPs)).

1.4 Pre-Enrollment Review
Instruction Sheet

Complete the following:

1. **Child's Name:** Write the name (first and last) of the child applying for the HS/EHS program.

2. **DOB (Date of Birth):** Write in the month, day, and 4-digit birth year of the child.

3. **Parent/Guardian Name/Telephone/Email**: Write in family information.

4. **Early Head Start/Head Start (EHS/HS) Site:** Write the name of the potential site being considered for placement.

5. **Application Date:** Write the date that the application was completed.

6. **ATTACH:** Attach supporting documentation and a completed Authorization to Release Information form for each of the child's providers (including as applicable: physician, school district, Regional Center, Rady Children's, etc.) listing the provider's name, address, and telephone number so that NHA staff can contact and acquire pertinent information regarding the child's condition(s).

7. **Health and Nutrition**: This section is completed when a severe health and/or nutrition concern is identified at intake. See Criteria SOPs.

    a. **Health Condition**: Mark all boxes that apply.

    b. **Medications and/or Adaptive Equipment**: Indicate any medications that must be taken or adaptive equipment that must be used for the child to fully participate in the program. If none are needed, mark the "N/A" box.

    c. **Additional Comments:** Add further details as needed.

    d. **Signature and Date:** EHS/HS staff completing this section signs.

8. **FSS/EHS PA/HB Supervisor Verification:** FSS/EHS PA/Home Base Supervisor (HB Sup) reviews Application and PER for completion. If more information is required, FSS/EHS PA/HB Sup contacts the appropriate person. FSS/EHS PA/HB Sup follows these steps:
    a. For children with health or nutrition concerns, submit CSQI PS SR. Attach the PER, completed Authorization to Release Information form, and supporting documents to the SR (scan, save, and upload to SR). Follow up with an email to the health or nutrition coordinator.

b. For disabilities or mental health concerns, provide PER to the ECE.
c. **NOTE:** For cases that meet PER criteria for health and/or nutrition AND disability and/or mental health, submit a CSQI PS SR to the Health or Nutrition Coordinator and provide PER to ECE. Inform ECE and CSQI Coordinator(s) for all contents involved in the PER.

9. **Status Recommendation:** The FSS/EHS PA/HB Sup marks this section based on PER.

    a. **Prioritization List** is marked if there is no follow up needed with CSQI Coordinators or ECE.

    b. **EHS/HS Applied** is marked if a CSQI PS SR was submitted to a Coordinator (Health, Nutrition, Disability or Mental Health). The Coordinator submits a CEU SR to request a Status Change (from Applied to Prioritization List) when the case is closed.

    c. **Only a Coordinator** may submit a CEU SR for this purpose.

10. **Developmental**- The ECE completes this section if the child has an IEP, IFSP and/or there is a disability or mental health concern identified by a professional other than by a Part B/Part C agency at intake.

    a. **Identified Disability (IEP/IFSP):** Mark "YES" if the child has an IFSP or IEP. Mark "NO" if they do not, even if there is documentation from a doctor, clinic or therapist. This will be covered in Section C below.

    b. **A. Primary disability/Current IEP/IFSP Date:**

        i. **Services:** List all special education services/interventions that the child is currently receiving along with the hours per week or hours per year that the child is receiving each service.
            1. For example, Speech and Language Therapy 30 hours per year, Occupational Therapy 2 times per week for 15 minutes, Adaptive Physical Education 4 hours per year.
        ii. **Part B/C Provider:** Write the name of the school district or Part C agency that is providing the child's special education services.
        iii. **Has Specialized Academic Instruction:** Check the "YES" or "NO" box to indicate if the child is currently enrolled in a Specialized Academic Instruction class. If "YES," the child must be referred for a Pre- Enrollment Case Conference.

c. **B. Non-IEP/IFSP related Disability or Mental Health (Social Emotional/Behavioral) Concern:** Mark "YES" or "NO" for this section if there is documentation from a doctor, clinic, therapist, or other service provider stating that the child has a disability or is receiving treatment for social/emotional and/or behavioral concerns. See list of examples on PER.

   i. Notify the Mental Health Coordinator for non-disability related social/emotional and/or behavioral concerns with a CSQI PS SR and a follow up email.

d. **Additional Comments:** Add further details as needed. This includes any secondary conditions or identified disabilities**.**

e. **Signature and Date:** ECE signs and dates after reviewing.

11. **Status Recommendation:** The ECE marks this section based on PER.

    a. **Prioritization List** is marked if there is no follow up needed with CSQI.

    b. **EHS/HS Applied** is marked if the ECE sent a CSQI PS SR to a Coordinator (Health, Nutrition, Disability or Mental Health).

12. **Filing**- Place completed PER and supporting information in the Child File.

13. **PROMIS Entry** (Only for children with IFSPs or IEPs): Once CEU has entered the child in PROMIS, the ECE adds the PER as a new service on the Disabilities Services Page. See PROMIS Record Keeping Section Disabilities: Entering Pre-Enrollment Review.

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

PRE-ENROLLMENT CASE CONFERENCE FOR CHILDREN WITH IDENTIFIED HEALTH AND/OR NUTRITION CONCERNS

Form completed by CSQI Health/Nutrition Coordinator(s) or CSQI Program Support staff ONLY

Type of PECC (check all that apply): □ Health □ Nutrition

Child's Name: _____ DOB: _____

1. **Has your child been enrolled in preschool before? □ Yes □ No**

2. **Do you have any concerns about your child's overall health & development or is your child diagnosed with a developmental delay and/or medical condition?**

   - **Child's Health Condition (if applicable, such as allergies, asthma, etc.):**

     _____
     _____
     _____

   - **Child's Nutritional Needs (if applicable, such as food allergies or chewing/swallowing issues):**

     _____
     _____
     _____

   - **Child's development (if applicable, such as diagnosed disability, social-emotional concerns):**

     _____
     _____
     _____

3. **Please list medication(s) that will be needed at school (non-emergency and emergency):**

   _____
   _____

4. **Does your child require a feeding tube at school? □ Yes □ No**
   If yes, please describe**:** _____

5. **Has your child been hospitalized due to his/her health condition in the last year? □ Yes □ No**
   If yes,
   Date: _____Length of Stay: _____

6. **Please list any adaptive equipment or materials that your child may need in school:**

   _____
   _____

7. **Will your child require accommodations in the classroom or outside? □ Yes □ No**
   If yes, please describe**:** _____

8. **Are there any restrictions to activities that the teacher and staff should be aware of? □ Yes □ No**
   If yes, please describe**:** _____

PRE-ENROLLMENT CASE CONFERENCE FOR CHILDREN WITH IDENTIFIED HEALTH AND/OR NUTRITION CONCERNS

9. **Does your child receive any other services? (check all that apply):**

□ **Speech/Language** □ **Physical Therapy** □ **Occupational Therapy**

□ **Behavioral Therapy (i.e. ABA)** □ **Mental Health Services** □ **Nutrition Counseling**

□ **Other (please describe):** _____

Note: include provider contact information and complete Authorization to Release Information

10. **Early Head Start/Head Start Placement:**

☐ To be determined

☐ Proposed Program

☐ Home Based

☐ Center Based Site: _____ ☐ Part Day AM ☐ Part Day PM ☐ Full Day

Will there be a variation in attendance? □ Yes □ No

If yes, please provide explanation: _____

13. **Is IHP or Special Meal Accommodations Needed?** □ Yes □ No

☐ Prior to 1st day of attendance *If known: Date: _____ Time: _____

Notes or Follow Up Items: _____

_____

_____

_____

_____	_____	_____	_____
Parent/Guardian	Date	Site Supervisor	Date
_____	_____	_____	_____
Teacher	Date	CSQI Staff	Date
_____	_____	_____	_____
Other	Date	CSQI Staff	Date

Original: Child File
Copy to Retain at Area Office: Attach PECC to Pre-Enrollment Review & health/nutrition related documentation.
Copy to Provide to CSQI Coordinator: Attach PECC to Pre-Enrollment Review health/nutrition related documentation.

PRE-ENROLLMENT CASE CONFERENCE FOR CHILDREN WITH IDENTIFIED MENTAL HEALTH AND DEVELOPMENTAL CONCERNS

Form completed by: CSQI Disabilities/Mental Health Coordinator or ECE/Disabilities Specialist ONLY

Type of PECC (check all that apply): □ Mental Health □ Disabilities

Child's Name: _____ DOB: _____

1. **Past early care/education experience □ Yes □ No**

   If "Yes," Previous program name_____ please share how the experience affected your child (socialization, behaviors, routines, etc.)_____
   _____
   _____
   _____

2. **Do you have any concerns about your child's overall health & development or is your child diagnosed with a developmental delay and/or medical condition?**
   _____
   _____
   _____

3. **Does your child receive any other services? (check all that apply):**

   □ Speech/Language □ Physical Therapy □ Occupational Therapy
   □ Behavioral Therapy (i.e. ABA) □ Mental Health Services □ Nutrition Counseling
   □ Other (please describe): _____

   Note: include provider contact information and complete Authorization to Release Information

4. **Strengths, interests and resources (Developmental and other):**

   Child: _____
   _____
   _____
   _____

   Family: _____
   _____
   _____

5. **Area of Concerns:**

   Child: □ Speech/Language □Cognitive □Gross/Fine Motor □Social/Emotional □Sensory □Challenging Behavior (triggers and responses) □Wandering (actions and environment) □Other
   _____
   _____
   _____
   _____
   _____

   Family: _____
   _____
   _____
   _____
   _____

PRE-ENROLLMENT CASE CONFERENCE FOR CHILDREN WITH IDENTIFIED MENTAL HEALTH AND DEVELOPMENTAL CONCERNS

6. **Will your child require accommodations and/or modifications in the classroom or outside?**

   ☐ **Yes** ☐ **No** **If yes, please describe:** _____

   Adaptive equipment or material needed: _____

7. **Are there any restrictions to activities that the teacher and staff should be aware of?** ☐ **Yes** ☐ **No**
   If yes, please describe**:** _____

8. **Family goals and expectations for placement in EHS/HS program:**
   _____
   _____
   _____

9. **ECSE/Separate Special Education Site (if applicable):**

   School Name: _____ Teacher Name: _____
   Days/Hours: _____Contact Information: _____
   Transportation: _____

10. **Early Head Start/Head Start Placement:**
    ☐ To be determined
    ☐ Proposed Program
        ☐ Home Based
        ☐ Center Based Site: _____☐ Part Day AM ☐ Part Day PM ☐ Full Day
        Will there be a variation in attendance? ☐ Yes ☐ No

        If yes, please explain and write days/hours of varied attendance: _____
        _____

11. **Follow-Up needed (if applicable):**
    ☐ Prior to enrollment; Date: _____ Time: _____

    ☐ Prior to first day of attendance; Date: _____ Time: _____

    ☐ Within first 30 days of attendance; Date: _____ Time: _____
    _____

Items to follow up**:** _____
_____
_____

☐ Phone interview with parent/guardian conducted on: ___ / ___ / ___

_____	_____	_____	_____
Parent/Guardian	Date	Site Supervisor	Date
_____	_____	_____	_____
Teacher	Date	CSQI Staff (if applicable)	Date
_____	_____	_____	_____
ECE/Disabilities Specialist	Date	Other	Date

Original: Child File
Copy to Retain at Area Office: Attach PECC to Pre-Enrollment Review, IEP/IFSP, and any health related documentation.
Copy to Provide to CSQI Coordinator: Attach PECC to Pre-Enrollment Review, IEP/IFSP, and any health related documentation.

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)

Child File Transfer Form

Child's Name: _____ **DOB**: _____ **FID**: _____ **PID**: _____

Current Site/Caseload: _____ **Site/Caseload Transferring to**: _____

CHECK ALL BOXES THAT APPLY:

□ Immunizations current

□ DRDP & Portfolio Attached (Current site must contact IT to transfer child in Learning Genie)

□ Foster Child or CWS Involved Family

□ Court Order

□ Current Intervention/Safety Plan

□ Family certified for CDE (if applicable)

CHECK BOXES THAT APPLY AND LIST DATES:

□ Current Physical Date: _____

□ Current Dental Date: _____

□ IEP/IFSP Date: _____

□ Date Child was Referred for Special Education (SEEC, SLP, EFRC): _____

□ IHP Date: _____

□ Current Authorization to Administer Medication Form Dated: _____

List Name(s) of Medication: _____

_____

(Current site must return all medication to the family prior to transfer)

□ Request for Special Meals Form Date: _____

(Receiving site must notify Central Kitchen of transfer date)

File Delivered By: _____ Signature_____ Date: _____
Print Name

File Received By: _____ Signature_____ Date: _____
Print Name

ORIGINAL SITE/CASELOAD: KEEP A COPY FOR YOUR RECORDS **RECEIVING SITE/CASELOAD: FILE FORM IN SECTION 1**

SECTION 2 – HEALTH & NUTRITION

Table of Contents

EHS Services to Pregnant Women

- Progress Notes- Health/Nutrition
- 2.14 Physical for Pregnant Women (for SPW only)
- 2.15 Perinatal Diet Questionnaire (for SPW only)
- 2.16 Pregnancy Outcome Form (for SPW only)
- 2.17 Prenatal Dental Exam Form (for SPW only)
- 2.18 Newborn Baby Visit (for SPW only)
- 2.19 Newborn Child Application Update Form (for SPW only)
- Authorization to Release Information **(if applicable)**

2.14 Physical for Pregnant Women (Pregnancy History/Prenatal Risks Assessment) Instruction Sheet

PURPOSE STATEMENT:
This form provides the participant's prenatal health care provider an opportunity to document a participant's medical history and current prenatal medical status. The information obtained from the form allows the Services to Pregnant Women (SPW) Perinatal Home Visitor to individualize each participant's services.

TIMELINE:
The SPW Perinatal Home Visitor provides the participant with the form at time of enrollment and obtains the completed form in a timely manner.

STAFF RESPONSIBLE:
SPW Perinatal Home Visitor

INSTRUCTIONS:

- SPW Perinatal Home Visitor fills out the upper portion of the form (participant information) and provides it to the participant for her physician to complete. If the participant does not have access to a medical provider, SPW Perinatal Home Visitor provides a referral to a medical provider and documents the referral in the Participant File and PROMIS.

- Upon receipt of the completed physical, staff will review the results with the participant. Staff must follow-up on any abnormal findings or recommendations by the attending physician. If necessary, ask the participant to complete an Authorization to Release Information form in order to communicate with the physician's office.

- Document the dates and results of the physical on the Prenatal Tracking Log, and in PROMIS under Pregnancy History/Prenatal Risks Assessment. File the form in the Participant File under Section 2: Health & Nutrition.

PHYSICAL FOR PREGNANT WOMEN
(Pregnancy History/Prenatal Risks Assessment)

Please provide the information requested below for your patient. This information will be used by staff of the Early Head Start program to provide a comprehensive and individualized prenatal/postpartum program to benefit your patient and her unborn child.

Patient's Name: (PRINT) First_____ Last_____	Patient's Address: Street _____ Apt. # _____ City _____, CA ZIP _____
Phone Number: ( )	Date of Birth:

Date of first prenatal visit: _____ **# of previous pregnancies (including miscarriages):** _____

Have you or any family members experienced Perinatal Depression? ☐ no ☐ yes

If yes, explain: _____

Woman's Current (Prenatal)

Height:_____inches Weight:_____lbs. Measurement Date: _____ /_____ /_____

Hemoglobin: _____ and/or Hematocrit: _____ Blood Test Date: _____ /_____ /_____

Proof of Pregnancy (weeks gestation)_____ **Due Date**: _____ /_____ /_____

Complications experienced during pregnancy:

☐ Swelling	☐ Hypertension	☐ Abdominal Pain
☐ Low Birth Weight	☐ Anemia	☐ Chronic Fatigue
☐ Uterine Irritability	☐ Diabetes	☐ Pre-term labor
☐ Sickle Cell Anemia	☐ Headaches	☐ Anxiety
☐ Stress	☐ Vaginal Bleeding	☐ Other: _____

List any current medications/supplements prescribed:

_____

_____

Comments:

_____

_____

_____ _____ ___ / ___ / ___

Print Name of Doctor Signature/Official Stamped Signature Date

Phone: _____ Fax: _____

EHS Staff Only
Date Received:

____ / ____ / ____

2.15 Perinatal Diet Questionnaire
Instruction Sheet

PURPOSE STATEMENT:
The purpose of the Perinatal Diet Questionnaire form is to document the nutritional status of the perinatal participant (Services to Pregnant Women (SPW) participant).

TIMELINE:
Completed at the time of enrollment

STAFF RESPONSIBLE:
SPW Perinatal Home Visitor

INSTRUCTIONS:

- Complete the upper portion of the form with the participant's name, the participant's date of birth, and participant's pregnancy due date.
- Staff interviews the participant and documents the answers on the form.
- In the comments section, explain starred responses and note if the participant has been referred to the agency's Registered Dietitian (Nutrition Coordinator) or an outside agency, such as MotherToBaby CA.
- Document any referrals in the Participant File, Section 2: Health and Nutrition, and in PROMIS.

PERINATAL DIET QUESTIONNAIRE

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

Pregnancy Due Date: _____ /_____ /_____

1. How are you feeling about this pregnancy?_____
2. When was your first prenatal visit for this pregnancy?_____
3. What was your weight before you became pregnant?_____
4. How much weight have you been advised to gain?_____
5. Have you ever had, or do you now have, a health or medical condition such as asthma, diabetes, depression, epilepsy, etc.?
   - ☐ No
   - ☐ Yes* If yes, please describe: _____
6. Do you take any of the following? (check all that apply)
   - ☐ Prenatal Vitamin
   - ☐ Multi-vitamin
   - ☐ Herbs or herbal remedies
   - ☐ Children's Vitamin
   - ☐ Iron
   - ☐ Medication: _____
   - ☐ None of these
7. What are your thoughts about breastfeeding?
   - ☐ Good idea, I plan to exclusively breastfeed my baby
   - ☐ Not sure, I would like more information
   - ☐ I plan to both breastfeed and formula feed my baby
   - ☐ I plan to feed my baby formula
8. Do you ever drink wine, beer or liquor?
   - ☐ No
   - ☐ Yes* date of last alcoholic drink _____
   - ☐ I would like to quit*
9. What best describes your smoking history?
   - ☐ Never smoked
   - ☐ Smoked, but I quit on _____ (month and year)
   - ☐ Currently smoke: _____ (# of cigarettes per day)*
   - ☐ I would like to quit*
10. Does anyone else living in your household smoke inside the home?
    - ☐ No
    - ☐ Yes*
11. Since you have been pregnant, have you taken any other drug(s) such as meth, crack, cocaine or marijuana?
    - ☐ No
    - ☐ Yes*
    - ☐ I would like to quit*
12. Have you seen a dentist during this pregnancy?
    - ☐ Yes
    - ☐ No, I would like to find a dentist*

PERINATAL DIET QUESTIONNAIRE

13. Do you have a cavity to be filled or tooth to be pulled?
    - □ No
    - □ Yes*

14. Check any of the following that you are experiencing:

□ Feeling sick to my stomach	□ Constipation	□ Eating all the time
□ Throwing up	□ Food cravings	□ No appetite
□ Heartburn	□ Diarrhea	□ Cravings for non-food items*
		□ None of the above

15. Are you following a prescribed special diet, weight control diet, vegan or macrobiotic way of eating?
    - □ No
    - □ Yes* If yes, please describe: _____

16. How many times a day do you usually eat? _____# meals per day _____ # snacks per day

17. How would you describe your appetite? □ Good □ Fair □ Poor

18. Do you ever drink raw/un-pasteurized milk or juice?
    - □ No
    - □ Yes*

19. Do you eat fish more than 2 times a week?
    - □ No
    - □ Yes*

20. Do you eat soft cheeses, such as feta, or raw cheeses?
    - □ No
    - □ Yes*

21. Which group of foods below do you find most challenging to eat enough of?

□ Milk, yogurt, cheese	□ Protein foods like: meat, fish, eggs, beans
□ Fruits	□ Vegetables
□ Bread, cereal, rice, pasta	□ Other: _____

22. How would you describe your daily activity? (check one)
    - □ Very active (cardio, weights, Yoga, Pilates)
    - □ Somewhat active (easy walking, light housework)
    - □ Moderately active (brisk walking, biking, hiking)
    - □ Not active (sit most of the day)

Comments: (Explain starred responses and note if the client has been referred to a Registered Dietitian, or other nutrition referral, or an outside agency)

_____

_____

_____

Participant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

2.16 Pregnancy Outcome Form
Instruction Sheet

PURPOSE STATEMENT:
The purpose of the Pregnancy Outcome Form is to document the outcome of the client's delivery.

TIMELINE:
Complete within a timely manner after the birth of the baby.

STAFF RESPONSIBLE:
Services to Pregnant Women (SPW) Perinatal Home Visitor

INSTRUCTIONS:
- Interview the participantin person during the first postpartum visit. If the participantis still in a period of transition, the interview can be completed over the phone.
- Complete all of the requested information and note any additional comments.
- Enter the information in PROMIS under "Pregnancy History/Pregnancy Outcomes."

PREGNANCY OUTCOME FORM

SPW Participant's Name: _____ Date of Interview: ____/____/_____

Date of Delivery: _____ /_____ /_____ Date of Discharge: _____ /_____ /_____

ABOUT MOTHER

☐ Ectopic Pregnancy ☐ Stillborn ☐ Induced Abortion ☐ Live Birth

Premature labor: ☐ yes ☐ no	Service Provider: _____

Delivery Location: _____ ☐ C-section ☐ Vaginal

Nursery Type: ☐ Intensive Care ☐ Regular ☐ Special	Gestational age (weeks): _____

Plurality: ☐ Singleton ☐ Twin ☐ Triplet ☐ Quad or higher ☐ N/A

Complications associated:

☐ Abruptio placentae	☐ Fetal distress	☐ Postpartum hemorrhage
☐ Other	☐ Placenta previa	☐ Premature membrane rupture
☐ Pre-eclampsia/Eclampsia	☐ Pre-term labor	☐ None of the above

Comments:

ABOUT INFANT

Child's name:_____
First Middle Last

DOB: _____ / _____ /_____	Gender: ☐ male ☐ female
Birth weight: _____ lbs. _____ oz.	Birth length: _____ inches

2.17 Oral Health Form-Pregnant Women
Instruction Sheet

PURPOSE STATEMENT:
The purpose of the Oral Health Form-Pregnant Women is to document the participant's prenatal oral health exam.

TIMELINE:
Services to Pregnant Women (SPW) Perinatal Home Visitor provides the participant with the form at time of enrollment and obtains the completed form in a timely manner.

STAFF RESPONSIBLE:
SPW Perinatal Home Visitor

INSTRUCTIONS:

- SPW Perinatal Home Visitor fills out the upper portion of the form (participant information) and provides it to the participant for her dentist to complete. If the participant does not have access to a dental provider, the SPW Perinatal Home Visitor provides a referral to a dental provider and documents the referral in the Participant File, Section 2: Health and Nutrition, and in PROMIS.

- Upon receipt of the completed oral health form (dental exam), staff will review the results with the participant. Staff must follow-up on any treatment needs, referrals to specialty care, and additional information noted by the dentist. If necessary, ask the participant to complete an Authorization to Release Information form in order to communicate with the provider.

- Document the dates and results of the oral health exam on the Prenatal Tracking Log, and in PROMIS – Oral Health. File the form in the Participant File under Section 2: Health & Nutrition.

THE NATIONAL CENTER ON Health

Head Start Oral Health Form—Pregnant Women

Patient Information

Patient's name | Date of birth | Phone number

Address | City | State | Zip code

Date of Exam and/or Treatment _____ / _____ / _____ This practice is the patient's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the patient have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Does the patient have gum disease? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____/_____(month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

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2.18 Newborn Baby Visit
Instruction Sheet

PURPOSE STATEMENT:
The purpose of the Newborn Baby Visit form is to document the first postpartum home visit. Perinatal staff is required to contact the family within 2 weeks of the delivery to schedule the Newborn Visit to determine the well-being of both the mother and child.

TIMELINE:
Completed within two weeks of the child's birth

STAFF RESPONSIBLE:
Services to Pregnant Women (SPW) Perinatal Home Visitor

INSTRUCTIONS:

1. Complete the top portion of the form with the child's name and date of birth, name of parent(s), current phone number, place where the visit was conducted, and the name of the EHS staff in attendance.

2. List the name of the medical provider and the child's pediatrician. Mark whether the baby has had their first doctor visit. If yes, list the date of the visit. Mark off whether the participant has scheduled their six-week postpartum visit. If yes, list the date of the visit.

3. Place a check mark after each topic is discussed. Document any comments/follow-up notes. After discussing the topic of child care options, update the participant's IFPA regarding transition goals.

4. Sign and date the form. If the visit was conducted jointly with other health professionals, obtain the person's signature and list the Perinatal Home Visitor's name at the top of the form under "EHS staff in attendance."

5. In the comments section, list any notes or follow-up needed. Document any referrals in the Participant File, Section 2: Health and Nutrition, and in PROMIS.

Newborn Baby Visit

Name of Child_____ DOB: _____

Name of Parent(s) _____

Current Phone: _____

Place of Visit: □ Home □ Other _____

EHS Staff in attendance: _____

Medical Provider: _____

Name of Pediatrician: _____

Has the baby had his/her first doctor visit?

□ No □ Yes Date: _____

Have you scheduled your 6-week postpartum visit?

□ No □ Yes Date: _____

INFORMATION DISCUSSED

___ Any medical condition
___ Special Needs (medical, nutrition, developmental)
___ Jaundice
___ Urine output and bowel movement
___ Skin care
___ Cord care
___ Feeding your baby (breast or bottle)
___ Burping your baby
___ Bathing your baby
___ Talking to your baby
___ Diapering your baby
___ Where does baby sleep?
___ Choosing a pediatrician
___ Circumcision
___ Baby's first visit to the doctor (what to expect)
___ Postpartum doctor visit
___ Infant car seat (correct position)
___ Passive smoking
___ Support system
___ Family planning options
___ Father's feelings/questions
___ Child care options
___ All about my baby
___ Basic baby needs

Comments/follow-up:

_____

_____

_____

_____ _____

Staff Signature Date of Visit

_____

Staff Title

CLIENT'S WRITTEN REFUSAL OF SERVICES

I, _____, client of the NHA Services to Pregnant Women program
(Print Name)

refuse to: (*Indicate the specific procedure(s)/service(s) being declined below)*

_____

_____

_____

_____

_____

REASON FOR REFUSAL:

_____

_____

_____

_____

_____

Staff described the benefits and reasons for the recommended procedure(s), and I still exercise my right to refuse the above listed services.

_____ _____
Client's Signature Date

_____ _____
Staff Signature Date

NOTE: NOT TO BE USED FOR IMMUNIZATIONS

SECTION 6 - MENTAL HEALTH

Table of Contents

Early Head Start

- Progress Notes-Mental Health
- 6.1 ASQ:SE 2(Ages and Stages Questionnaire: Social Emotional)
- 6.1A ASQ:SE 2 Screening Results Review
- 6.2 Edinburgh Postnatal Depression Scale (**for SPW only**)
- Service Request Copy (**if applicable**)
- Authorization to Release Information (**if applicable**)
- ABC Checklist (**if applicable**)

The following forms are for CSQI Program Support use only (if applicable):

- Consent for Secondary Assessment
- Service Request Response Form
- Case Conference Form
- Classroom/Child Observation Guide
- CSQI Program Support Observation Notes
- Intervention Plan
- Intervention Plan Review Form
- Notification of Appropriate Program Option/Variation of Attendance Process Form (NAPOVAP)

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have copied quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS) SPANISH

Spanish

SUS SENTIMIENTOS DURANTE LA SEMANA PASADA

1. He podido reír y ver el lado bueno de las cosas:
   - Tanto como siempre
   - No tanto ahora
   - Mucho menos
   - No, no he podido

2. He mirado al futuro con placer:
   - Tanto como siempre
   - Algo menos de lo que solía hacer
   - Definitivamente menos
   - No, nada

3. Me he culpado innecesariamente cuando las cosas marchaban mal:
   - Sí, la mayor parte de las veces
   - Sí, algunas veces
   - No muy a menudo
   - No, nunca

4. He estado ansiosa y preocupada sin motivo:
   - No, nada
   - Casi nada
   - Sí, a veces
   - Sí, a menudo

5. He sentido miedo y pánico sin motivo alguno:
   - Sí, bastante
   - Sí, a veces
   - No, no mucho
   - No, nada

6. Las cosas me superaban, me sobrepasaban:
   - Sí, la mayor parte de las veces
   - Sí, a veces
   - No, casi nunca
   - No, nada

7. Me ha sentido tan infeliz, que he tenido dificultad para dormir:
   - Sí, casi siempre
   - Sí, a veces
   - No muy a menudo
   - No, nada

 Translated from Cox, J. L., Holden, J. M. & Sagovsky, R. (1987) Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* **150**, 782–786.

8. Me he sentido triste y desgraciada:
   Sí, casi siempre
   Sí, bastante a menudo
   No muy a menudo
   No, nada

9. He sido tan infeliz que he estado llorando:
   Sí, casi siempre
   Sí, bastante a menudo
   Sólo ocasionalmente
   No, nunca

10. He pensado en hacerme daño a mí misma:
    Sí, bastante a menudo
    A veces
    Casi nunca
    No, nunca

6.2 Edinburgh Postnatal Depression Scale
Instruction Sheet

PURPOSE STATEMENT:

Prenatal and Postpartum depression is the most common complication of childbearing. The Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying women at risk for perinatal depression.

TIMELINE:

The EPDS is completed twice. It is completed at the time of enrollment and again after the birth of the baby. The screening tool was designed to be used ideally around 6-8 weeks postpartum (i.e. after child's birth), and no earlier than two weeks postpartum.

STAFF RESPONSIBLE:

Services to Pregnant Women (SPW) Perinatal Home Visitor

INSTRUCTIONS:

- Complete the upper portion of the tool with the client's information.
- The enrolled SPW client reads through the EPDS and answers all questions as truthfully as possible based on how the client has been feeling in the past 7 days, not just the day that the EPDS is being completed.
    - Care should be taken to avoid the possibility of the mother discussing her answers with others. Answers should only come from the SPW client.
    - When applicable, use the Spanish version of the EPDS. If the mother does not speak English or Spanish, a translator will be used as needed.
- Once the SPW client has completed the EPDS, the Perinatal Home Visitor will review and score it. There is a maximum score of 30 points; 10 or greater may indicate possible depression.
- **A score of 1-3 in response to question #10 indicating possible suicidal thoughts requires immediate attention. Contact the *Access and Crisis Hotline***

at 1-888-724-7240 while you are with the client, and submit a CSQI Service Request for additional mental health support.

- If the total score is between 5-9 points, the Perinatal Home Visitor will discuss with the client whether there is a need for further assistance, offer support and education about postpartum depression, as well as monitor client behavior.
- If the total score is 10 or above, the Perinatal Home Visitor will provide a referral to the appropriate agency, such as the Postpartum Health Alliance and send a service request to the CSQI team for follow-up. Any referrals and follow-up must be documented in PROMIS and in the Progress Notes of Section 6 in the participant's file.
- EPDS is entered into PROMIS as a Mental Health Screening. File the document in Section 6: Mental Health of the participant's file.

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

Authorization to Release Information
Instruction Sheet

PURPOSE

The Authorization to Release Information form is completed by the parent/guardian to grant Neighborhood House Association (NHA) authorization to contact an outside agency to request medical, psychological, educational, or other information/records. This information is used to determine appropriate placement or individualize the program to meet the child's needs.

TIMELINE

The Authorization to Release Information form is completed with the parent/guardian whenever the site/program needs to request information/records from an outside agency or office (i.e. doctor, clinic, Child Welfare Services, dental office, First 5 program, local educational agency, Early Intervention Program, etc). The Authorization may be completed at any time throughout the program year.

STAFF RESONSIBLE

Family Service Advocate, Home Visitor, Teacher, Site Supervisor/Assistant Site Supervisor, Family Services Supervisor, Home-Based Supervisor, ECE/Disabilities Specialist, Comprehensive Services and Quality Improvement (CSQI) Program Support, or any other staff member

INSTRUCTIONS

Each section of the Authorization to Release Information form must be completely filled out prior to the parent/guardian signing the document.

All children with IEPs must have completed authorization forms for the responsible local educational agency, and all children with IFSPs must have authorization forms for Regional Center/Early Start.

An Authorization to Release Information form is only valid for the program year in which it is signed.

Staff completes the following:

- **Child-** Write the first and last name of the child.
- **Date of Birth-** Write in the month, day, and birth year of the child.
- **Center-** Write the name of the site the child attends.
- **Parent/Guardian Name-** Write the name of the child's parent/guardian.
- **Phone #/Work #-** Write the home/cell, and/or work telephone numbers, including area codes, of the parent/guardian.
- **Address-** Write the address of the parent/guardian: Street address, Unit # (if applicable), City, and Zip Code.

Authorization to Release Information
Instruction Sheet

Requesting Records from:

- Write the name of the agency, doctor, dentist, or organization from which you are requesting information.
- Write the phone number and fax number of the releasing agency/office.

Record Requestor:

- **Phone # and Fax #** - The telephone and fax numbers of the Early Head Start/Head Start (EHS/HS) site, or support staff office contact information, may be filled in here.

To release any:

- Check the appropriate box indicating the type of information you are requesting – Medical, Psychological, Education, or Other.
- "Specify Requested Record~~s~~(s)" - write the name or type of record/information needed (i.e. TB, immunization, IEP, dental, etc.).

Requested record will be used for the following purpose(s):

- Check all boxes that apply.
- To individualize the program – This option is used when obtaining medical records, psychological, and educational records.
- To determine placement – This option is most often used when requesting IEP or education assessments.
- If the "other" box is checked, be sure to indicate for what purpose the records will be used.

Signatures

- Ask the parent/guardian to review the form. By signing the form, the parent/guardian authorizes NHA to contact, and exchange information as identified on the release, with the identified agency.
- Write the relationship of the parent/guardian to the child (i.e., mother, foster parent, grandmother, etc.).
- The EHS/HS staff assisting the parent/guardian signs on the "Staff Signature" line and writes the date the form was completed and signed.

File the completed Authorization to Release Information form in the appropriate section of the Child File based on the records requested. For example, medical record release is filed in Section 2 of the Child File.

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.**

SPW PROGRESS NOTES

Participant's Name:	Date of Birth:
Caseload:	Perinatal 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

Progress Notes
Instruction Sheet

PURPOSE:

Staff is required to record and maintain information about children and families. Documentation is to be current, accurate, factual, and objective.

Progress Notes are used to record contact with the family, updates about the children, and the work completed by staff as it relates to each section of the file.

TIMELINE:
The Progress Notes are updated throughout the child/family's involvement with Early Head Start/Head Start, beginning with enrollment/registration. The Progress Notes are updated regularly, as needed.

RESPONSIBLE STAFF:

Site Supervisor/Assistant Site Supervisor, Family Service Advocate, Home Visitor, Teacher, Assistant Teacher, Early Childhood Education/Disabilities Specialist, Comprehensive Services & Quality Improvement Program Support, and other staff as required

INSTRUCTIONS:

This form is to be used to document activities related to Enrollment and Attendance (Section 1), Health and Nutrition (Section 2), Family Partnerships (Section 3), Education (Section 4), Disabilities (Section 5), and Mental Health (Section 6).

- Complete the form in ink
- Print information legibly
- Complete top section of Progress Note sheet, including Child's Name, Date of Birth, Site/Classroom, and Teacher/Home Visitor name.
- Mark the content area that applies and file the Progress Note in the corresponding content section.
- Each entry must include:
    - Date
    - An objective and specific statement of work completed and/or contact with the family
- Staff making an entry must PRINT their name (first initial and last name); staff shall not use legal signatures.

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.