STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

# IDENTIFICATION AND EMERGENCY INFORMATION
# CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

**To Be Completed by Parent or Authorized Representative**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CHILD'S NAME | LAST | | MIDDLE | | FIRST | SEX | TELEPHONE ( ) |
| ADDRESS | NUMBER | STREET | | CITY | STATE | ZIP | BIRTHDATE |
| FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME | LAST | | MIDDLE | | FIRST | | BUSINESS TELEPHONE ( ) |
| HOME ADDRESS | NUMBER | STREET | | CITY | STATE | ZIP | HOME TELEPHONE ( ) |
| MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME | LAST | | MIDDLE | | FIRST | | BUSINESS TELEPHONE ( ) |
| HOME ADDRESS | NUMBER | STREET | | CITY | STATE | ZIP | HOME TELEPHONE ( ) |
| PERSON RESPONSIBLE FOR CHILD | LAST NAME | | MIDDLE | FIRST | HOME TELEPHONE ( ) | | BUSINESS TELEPHONE ( ) |

## ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

| NAME | ADDRESS | TELEPHONE | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

| | | | |
|---|---|---|---|
| PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( ) |
| DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( ) |

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

## NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

| NAME | RELATIONSHIP |
|---|---|
| | |
| | |
| | |
| | |
| | |

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

## TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

| DATE OF ADMISSION | DATE LEFT |
|---|---|
| | |

# CHILD'S PREADMISSION HEALTH 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 |
|---|---|

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# PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

**IMMUNIZATION HISTORY:** (Fill out or enclose California Immunization Record, PM-298.)

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|---|---|---|---|---|---|
| | 1st | 2nd | 3rd | 4th | 5th |
| POLIO (OPV OR IPV) | / / | / / | / / | / / | / / |
| DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY) | / / | / / | / / | / / | / / |
| MMR (MEASLES, MUMPS, AND RUBELLA) | / / | / / | | | |
| HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B) | / / | / / | / / | / / | |
| HEPATITIS B | / / | / / | / / | | |
| VARICELLA (CHICKENPOX) | / / | / / | | | |

**SCREENING OF TB RISK FACTORS** (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

**RISK FACTORS FOR TB IN CHILDREN:**

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

# 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.**

# CONSENT FOR EMERGENCY MEDICAL TREATMENT-
## Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

| HOME PHONE | WORK PHONE |
|---|---|
| (  ) | (  ) |

# 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) |
|---|---|
| | |

# INFANT/TODDLER NEEDS AND SERVICES PLAN

Child's name_____
Date of birth _____
Enrollment date _____

## FEEDING PLAN

Breastfed or Formula_____
Amount_____
Feeding schedule_____
Does child eat solid foods? Yes____ No ____
Consistency of food?_____
Schedule for intro. of solid and/or new food_____
Favorite foods_____
Disliked foods_____
Allergies?_____
Does child use cup/utensils?_____
Does child feed him/herself?_____
Schedule for intro. of cup/utensils_____
Current meal times: B_____ L _____ Snack _____ D _____

## TOILET TRAINING PLAN

Is child in diapers? Yes____ No ____
Have you begun potty training? Yes____ No____
What method would you like used to potty train?_____
Word used for urination?_____
Word used for defecation?_____
What date would you like training to start?_____

## SLEEPING

Child usually goes to bed at_____
Child usually awakes at_____
Does child nap during the day? Yes____ No____
Time of nap_____
How long does child usually sleep? _____

_____ _____
Parent Signature Date