

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) (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
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.

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:

Department of Public Social Services - Los Angeles Northwest Child Care

NAME

Department of Public Social Services - Los Angeles Northwest Child Care

ADDRESS

6167 Bristol Parkway

CITY

Culver City

ZIP CODE

90230

AREA CODE/TELEPHONE NUMBER

310-337-4335

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)

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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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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? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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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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 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: Department of Public Social Services - Los Angeles Northwest

Licensing Office Address: 6167 Bristol Parkway, Culver City, CA 90230

Licensing Office Telephone #: 310-337-4335

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

LIC 995 (9/08)

Parents of Children In or Entering School or Child Care



REFERENCE

Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

WHY YOUR CHILD NEEDS SHOTS

The California School Immunization Law requires that children be up-to-date on their immunizations (shots) to attend school or child care. Diseases like chickenpox, measles, and whooping cough spread quickly, so children need to be protected before they enter. Most children need booster shots before starting kindergarten. 7th grade entry requirements went into effect July 1, 1999. A varicella (chickenpox) requirement for kindergarten entry and child care attendance went into effect July 1, 2001.

WHAT YOU WILL NEED AT REGISTRATION

You will need your child's Immunization Record. It must show the date your child was given each required shot. If you do not have an Immunization Record or your child has not received all required shots, call your doctor or local health department now for an appointment.



THESE ARE THE SHOTS THAT ARE REQUIRED

Review your child's Immunization Record to make sure you have a date for each shot required.

Vaccine	NUMBER OF IMMUNIZATIONS REQUIRED TO ENTER, BY AGE OF CHILD							
	Child Care					School		
	2-3 months	4-5 months	6-14 months	15-17 months	18+ months	4-6 years	7-17 years	7th grade
Polio (OPV/IPV)	1	2	2	3	3	4 ^a	4 ^b	
DTP/DTaP	1	2	3	3	4	5 ^a	3 ^b	
Td Booster								[1 ^c]
MMR				1 ^d	1 ^d	2 ^e	1 ^e	2 ^e
Hepatitis B	1	2	2	2	3	3		3 ^f
Hib	1	2	2	1 ^d	1 ^d			
Varicella					1 ^g	1 ^g	1-2 ^h	

- ^a This number includes kindergarten boosters. If your child is 4-6 years old, entry requirements are met with only 3 polio and 4 DTPs if at least one polio and one DTP dose were after your child's fourth birthday.
- ^b For children 7-17 years old, entry requirements are met with only 3 polio and 3 DTP or DT/Td if at least one polio and DTP or DT/Td were after your child's 2nd birthday. For students age 7 years and older, pertussis immunization is not required.
- ^c A Td booster is recommended but not required.
- ^d One dose must be on or after the 1st birthday regardless of any doses received earlier. The Hib requirement applies only to child care children under age 4 years and 6 months.
- ^e One dose on or after the first birthday is required for grades 1-6 and 8-12. Mumps immunization is not required for students age 7 years and older.
- ^f Two doses of the 2-dose hepatitis B vaccine formulation along with provider documentation that the 2-dose hepatitis B vaccine formulation was used for both doses and both doses were received at age 11-15 years will also fulfill this requirement.
- ^g If your child had chickenpox disease, ask your doctor to note it on the immunization record to meet the requirement.
- ^h Required for children not enrolled in California schools before July 1, 2001. 1 dose required for grades K-12. For children 13-17 years old, 2 doses are needed if vaccine received after 13th birthday.

If your child's record is missing some doses, please contact your doctor or clinic now to obtain the full immunization record or any doses needed. If your child recently received immunizations and needs an immunization later in the year, he/she can be allowed to attend, provided you get the remaining doses when they become due.

Your child may be exempted from some or all immunizations by a doctor because of a medical condition. Your child may be exempted by you because of your personal or religious beliefs. Ask your school or child care provider for details.


CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

Child Care



REFERENCE Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCTIONS To attend child care, children must have immunizations outlined below by age. Parents must present their child's Immunization Record as proof of immunization. Copy the full date of each shot onto the blue California School Immunization Record card and then determine if the child is up-to-date. Blue cards are available free from the Immunization Coordinator at your local health department. As the child care provider, it is your responsibility to follow up regularly until all shots are finished.

IMMUNIZATIONS (SHOTS) REQUIRED TO ATTEND CHILD CARE, BY AGE	Age When Enrolling	Immunizations (Shots) Required	Vaccines
	2-3 months.....	1 each of Polio, DTaP, Hib, Hep B	DTaP : Diphtheria, tetanus, and pertussis combined vaccine. Record may show DT or DTP.
	4-5 months.....	2 each of Polio, DTaP, Hib, Hep B	
	6-14 months.....	3 DTaP	Hib : <i>Haemophilus influenzae</i> type b vaccine; required only for children up to age 4 years, 6 months. MMR : Measles, mumps, and rubella combined vaccine. Hep B : Hepatitis B vaccine. Varicella : Chickenpox vaccine.
	15-17 months.....	2 each of Polio, Hib, Hep B 3 each of Polio, DTaP 2 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib, on or after the first birthday ^{1,3}	
	18 months-5 years.....	3 Polio 4 DTaP 3 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib, on or after the first birthday ^{1,3} 1 Varicella (chickenpox) ²	

You may admit a child who is lacking one or more required vaccine doses if the dose(s) is not currently due **on the condition** that they receive the remaining dose(s) when due, according to the schedule above. You will need to review records to make sure this occurs. If the maximum time interval between doses has passed, the child cannot be admitted until the next immunization is obtained.

- ¹ Receipt of the dose up to (and including) 4 days before the birthday will satisfy the child care entry immunization requirement.
- ² If a child had chickenpox disease and this is indicated on the Immunization Record by the child's physician, they meet the requirement. Write "disease" in the chickenpox date box on the blue card.
- ³ Required only for children who have not reached the age of 4 years 6 months.

WHEN NEXT SHOTS ARE DUE	
Polio #2	6-10 weeks after 1st dose
Polio #3	6 weeks-12 months after 2nd dose
DTP or DTaP #2, #3	4-8 weeks after previous dose
Hib #2	2-3 months after 1st dose
DTP or DTaP #4	6-12 months after 3rd dose
Hep B #2	1-2 months after 1st dose
Hep B #3	Under age 18 months: 2-12 months after 2nd dose and at least 4 months after 1st dose Age 18 months and older: 2-6 months after 2nd dose and at least 4 months after 1st dose

EXEMPTIONS The law allows (a) parents/guardians to choose exemptions from immunization requirements based on their personal beliefs, and (b) physicians of children to choose medical exemptions from them. The law does not allow parents/guardians to choose an exemption simply because the "shot" record is lost or incomplete and it is too much trouble to get to a physician or clinic to correct the problem. The back of the blue California School Immunization Record has instructions and an affidavit to be signed by parents who want a personal beliefs exemption. An up-to-date list of children with exemptions should be maintained separately by the child care staff so that these children can be quickly identified and excluded from attendance if an outbreak occurs.