Form 1

REGISTRATION FORM

Child's full name _____ Date of birth _____

Child's address _____

_____

Phone number _____

Parent or guardian information

Parent or guardian's name _____

Address _____

_____

Phone number _____

Place and hours of employment _____

Address _____

_____

Phone number _____

Co-parent or guardian's name _____

Address _____

_____

Phone number _____

Place of employment _____

Address _____

_____

Phone number _____

Persons authorized to pick up child _____

_____

_____

Persons who may not pick up child _____

_____

Form 2

TELL US ABOUT YOUR CHILD

Child's Name _____

What would you like us to call your child? _____

If you would like to, please tell us about the people who live in the home with the child. _____

_____

What should we know about your child's health? _____

_____

Does your child have any allergies? If yes, what is your child allergic to? _____

_____

What are the symptoms? _____

_____

How severe? Is there an antidote? _____

_____

Does your child take any medicine regularly, If yes, what? _____

_____

Do you have any concerns about your child that you want to tell us about? _____

_____

Does your child have a disability that has been diagnosed? _____

_____

Food

What do you want us to know about your child's feeding and eating patterns? _____

_____

How do you feed him or her? _____

_____

If your child is eating solid foods

- Are there any food restrictions? _____
- What are his or her likes, and dislikes? _____

  _____
- Does your child feed him or herself? _____
- How? Eat with fingers? Use a spoon? Use a fork? Use chopsticks? Drink out of a cup?

_____

Do you have any concerns about your child's feeding that you want us to know about? _____

_____

Do you have any feeding or mealtime rituals that you want to tell us about? _____

_____

Diapering and Toileting

If your child is in diapers, do you use cloth or disposable diapers? _____

If old enough

- how does your child indicate bathroom needs? _____
- What words does he or she use? _____
- Is he or she toilet trained? _____
  If not, what are your ideas about when and how to begin? _____

Sleeping and Napping

- What are your child's sleeping patterns? _____
- What do you want us to know about how you put your child to sleep? _____
- Does your child have a favorite toy or item he or she uses for comfort? _____
- Is there anything in particular that frightens your child? _____
- How do you comfort your child? _____

Home Language

What do you want us to know about who speaks what language in your home? _____

If you had a choice, what language(s) would you want your child to hear and speak in the program?

_____

If your home language is not the language spoken in the program, do you want to teach us some key words in your language? _____

What else do you want us to know about you and your child? _____

Form 3

IDENTIFICATION AND EMERGENCY FORM

Date _____

Child's name _____

Child's physician _____ Phone _____

Address _____

_____

Child's dentist _____ Phone _____

Address _____

_____

Parent's or guardian's name _____

Phone where you can be reached in an emergency _____

Please notify us if this changes (even temporarily)

Co-parent's name _____

Phone where this person can be reached in an emergency _____

Other people who can be called in case of emergency (Be sure to include people who will usually know where you are)

Name _____ Relationship to the child _____

Address_____

Phone number _____

Name _____ Relationship to the child _____

Address_____

Phone number _____

First Aid

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

Signature/date _____

Emergency Care

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Signature/date _____

Health Record Transfer

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

Signature/date _____

Form 4

INFANT FEEDING PLAN

Child's name _____

Birth date _____

Breast fed or formula? _____

Type of formula (if applicable) _____

_____

Does your infant eat solid foods? _____

If yes, what foods have already been introduced? _____

_____

_____

What plan do you have for introducing new foods? Please give details of what new foods you plan to introduce and when?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent's signature _____

Caregiver's signature _____

Form 5

DAILY INFORMATION SHEET

Parent Section

Please give us any information that will help us to care for your child today:

Date _____

Child's name _____

Feedings _____

_____

Sleep _____

_____

Changes in elimination patterns _____

_____

Other _____

_____

Comments _____

_____

_____

Caregiver's Section

Dear Parent,

Here are how things went today

_____

_____

_____

_____

Feedings _____

Sleep _____

Diapers/toileting information _____

_____

Other _____

_____

Comments _____

_____

Form 6

SIGN-IN SHEET		
Date		
Child's name Write full name	Brought in by: Sign full name	Picked up by: Sign full name
1.	Time in_____	Time out _____
2.	Time in_____	Time out _____
3.	Time in_____	Time out _____
4.	Time in_____	Time out _____
5.	Time in_____	Time out _____
6.	Time in_____	Time out _____
7.	Time in_____	Time out _____
8.	Time in_____	Time out _____

Form 7

DIAPERING LOG Date		
Child changed	**Time**	**Comments**

Form 8

FEEDING LOG			
Child Fed	**Time**	**Description and Amount Consumed**	**Comments**

Form 9

ALLERGY NOTICE

To be prominently displayed

_____ is allergic to _____

CHILD'S NAME

_____ is allergic to _____

CHILD'S NAME

_____ is allergic to _____

CHILD'S NAME

_____ is allergic to _____

CHILD'S NAME

_____ is allergic to _____

CHILD'S NAME

_____ is allergic to _____

CHILD'S NAME

Form 10

SAMPLE EXPOSURE NOTICE

Note: The information contained below does not replace consultation with your physician if your child is sick.

Dear Parents:

On (date) _____ your child may have been exposed to the following disease:

_____

Onset of disease after exposure (how long): _____

The symptoms: _____

_____

This disease is spread by: _____

_____

It is contagious (when, for how long, at what stage): _____

_____

_____

It can be recognized/diagnosed by: _____

_____

Steps for treatment: _____

_____

_____

_____

Steps for preventsion: _____

_____

_____

_____

NOTE: *Keeping Kids Healthy* contains important facts about 26 communicable diseases most frequently encountered in child care programs.

Form 11

MEDICATION SCHEDULE				
Date	**Name**	**Medication**	**Dose**	**Times**

Form 12

INDIVIDUAL CHILD'S RECORD OF MEDICATIONS GIVEN

Dear Parent: Please complete this form and return along with medication.

Child's name _____

Illness _____

_____

Medication _____

_____

Dosage _____

_____

Dates to be given _____

Times to be given _____

I authorize the child care staff to administer the above medication from

_____ until _____

DATE DATE

Parent's signature _____ Date _____

This part will be filled out by the caregiver:

Date	Medication Given	Dose	Time given	Given by

Form 13

INCIDENT LOG					
Date time	**Name of child**	**Location**	**Type of incident**	**Action taken**	**Initials**

Form 14

INCIDENT REPORT

Child's name _____

Date of incident _____ Time of incident _____

Description of incident _____

_____

_____

_____

Place incident occurred _____

_____

Description of incident (including any equipment or product involved) _____

_____

_____

Description of injury and body part involved _____

_____

Name of witnesses _____

Action taken _____

Was parent called? _____

Was anybody else called? _____

Was doctor called? _____

Corrective action needed to prevent such incidents from reoccurring. _____

_____

_____

_____

Additional information _____

_____

_____

_____

_____

_____

Signature _____ Date _____

Form 15

DOCUMENTATION OF CONCERN FOR A CHILD

Date _____

Child's name _____

Nature of Concern _____

_____

_____

_____

_____

_____

_____

_____

Detailed Observation _____

_____

_____

_____

_____

_____

_____

Proposed action to be taken _____

_____

_____

_____

_____

_____

_____

_____

Signature _____

Form 16

HOW ARE WE DOING?
FAMILY FEEDBACK FORM

Are we meeting your needs? Do you have any ideas about how we could do a better job?

_____

_____

Are we meeting your child's needs? Do you have any ideas about how we could do a better job?

_____

_____

Are our policies clear to you?

_____

_____

How do you feel about the communication between you and your child's caregiver or caregiving team?

_____

_____

How well do they respond to your concerns?

_____

_____

What are some things you would like them to know to better understand you and your child?

_____

_____

How do you feel about the information you get about your child's day?

_____

_____

Are there things that you would like to see included in your child's day that aren't there now?

_____

_____

Do you think the program is respectful of diversity?

_____

_____

What else do you want to tell us?

_____

_____

Form 17

DEVELOPMENTAL HEALTH HISTORY

Child's name _____ Birth date _____/_____/_____
(Last) (First)

Nickname _____

Physical Health

What health problems has your child had in the past? _____

_____

_____

_____

What health problems does your child have now? _____

_____

_____

Other than what you listed above, does your child have any allergies? If so, to what? _____

_____

_____

How severe? _____

_____

Does your child take any medicine regularly? If so, what? _____

_____

Has your child ever been hospitalized? if so, when and why? _____

_____

_____

Does your child have any recurring chronic illness or health problem (such as asthma or frequent earaches)? _____

_____

Does your child have a disability that has been diagnosed (such as cerebral palsy, seizure disorder, developmental delay)? _____

_____

Do you have any other concerns about your child's health? _____

_____

_____

_____

Development (compared with other children this age)

Does your child have any problems with talking or making sounds? Please explain. _____

_____

Does your child have any problems with walking, running, or moving? Please explain. _____

_____

Does your child have any problems seeing? Please explain._____

_____

_____

Does your child have any problems using her or his hands (such as with puzzles, drawing, small building pieces)? Please explain. _____

_____

_____

Daily living

What is your child's typical eating pattern? _____

_____

_____

Write N/A (non applicable) if your child is too young for the following questions to apply:

What foods does your child like? _____

Dislike? _____

How well does your child use table utensils (cup, fork, spoon)?_____

_____

How does your child indicate bathroom needs? Word(s) for *urination:* _____

Word(s) for *bowel movement:* _____

Special words for body parts: _____

What are your child's regular bladder and bowel patterns? Do you want us to follow a particular plan for toilet training?_____

_____

For toddlers, please describe the use of diapers or toileting equipment at home (such as a potty, toilet seat adapter)_____

_____

What are your child's regular sleeping patterns?

Awakes at _____ Naps at _____ Goes to bed at _____

What help does your child need to get dressed? _____

_____

Social relationships/play

What ages are your child's most frequent playmates? _____

Is your child friendly? _____ Aggressive? _____ Shy? _____ Withdrawn? _____

Does your child play well alone? _____

_____

What is your child's favorite toy? _____

_____

What frightens your child? (Circle all that apply.) Animals? Rough children? Loud noises? The dark? Storms? Anything else? _____

_____

Who does most of the disciplining? _____

_____

What is the best way to discipline your child? _____

_____

_____

With which adults does your child have frequent contact? _____

_____

How do you comfort your child? _____

_____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

_____

_____

Parent's signature _____

Date _____

Form 18

PHYSICIAN'S REPORT FORM—DAY CARE CENTERS

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING

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) (DATE OF BIRTH)

_____. The 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:

Other:

Other (including behavioral concerns):

Comments/Explanations

MEDICATION PRESCRIBED/SPECIAL, ROUTINES/RESTRICTIONS FOR THE 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/DTEP/ DT/DD	(DIPTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR	(MIEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS	(REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B		/ /	/ /	/ /	/ /	/ /
VARICELLA	(NOT REQUIRED) (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

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

❑ Risk factors present; Mentoux 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