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 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 RUBELL)	/ /	/ /	/ /	/ /	/ /
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