

# 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  
( )

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

DATE OF ADMISSION	DATE LEFT
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# 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)

**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*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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**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 LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ 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*
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PARENT'S EVALUATION OF CHILD'S HEALTH
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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
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HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?
--

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?
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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
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PARENT'S SIGNATURE	DATE
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## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### 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](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### 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](http://www.meganslaw.ca.gov)*

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# California Pre-Kindergarten and School Immunization Record

Staff must record the required vaccine dose information and status of requirements for each pupil. See reverse side for guidance.

<b>Pupil Name</b> (Last, First, Middle):	<b>Statewide Student Identifier</b> (SSID):	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	<b>Race:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
<b>Name of Parent/Guardian</b> (Last, First):	<b>Birthdate</b> (Month/Day/Year):	<b>Gender:</b>	

Required Vaccine	Date Each Dose Was Given (MM/DD/YY)					Permanent Medical Exemption	Notes for School Requirements
	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>	5 <sup>TH</sup>		
<b>IPV / OPV</b> (Polio)			Age: ____ yrs.			<input type="checkbox"/>	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
<b>DTaP / DTP</b> – Age 0-6 years <b>Tdap / Td</b> – Age 7+ years (Diphtheria, Tetanus, Pertussis)			Age: ____ yrs.	Age: ____ yrs.		<input type="checkbox"/>	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7 <sup>th</sup> Grade requirement.
<b>MMR</b> (Measles, Mumps, Rubella)	Age: ____ mo.					<input type="checkbox"/>	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
<b>Hib</b> ( <i>Haemophilus influenzae</i> type b)						<input type="checkbox"/>	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
<b>Hep B</b> (Hepatitis B)						<input type="checkbox"/>	3 doses meet TK/K-12 requirement.
<b>VAR / VZV</b> (Varicella/Chickenpox)						<input type="checkbox"/>	2 doses meet TK/K-12 requirement.
<b>Tdap</b> – 7 <sup>th</sup> Grade (Tetanus, Diphtheria, Pertussis)	Age: ____ yrs.					<input type="checkbox"/>	1 dose given at age ≥7 years meets requirement for 7 <sup>th</sup> grade advancement and 7 <sup>th</sup> –12 <sup>th</sup> grade admission.

Status of Requirements	Staff Initials <i>I reviewed pupil's immunization record</i>	Has All Required Vaccine Doses	Requires Follow-up			Follow-up Date(s) (See conditional admission schedule or exemption end)	Other <i>See codes on reverse side</i>	Date Requirements Met
			Temporary Medical Exemption	Missing Doses Not Currently Due—Conditional	Missing Doses Are Overdue—Needs Doses Now			
<b>Pre-Kindergarten</b> (Child Care or Preschool)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> IEP	
<b>TK/K-12</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> IEP <input type="checkbox"/> IND <input type="checkbox"/> Home	
<b>7<sup>th</sup> Grade</b> (Advancement or Admission)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> IEP <input type="checkbox"/> IND <input type="checkbox"/> Home	

## Guidance For Completing Form CDPH 286

### Review the pupil's immunization record for admission to:

- Pre-kindergarten (child care or preschool);
- Transitional kindergarten/kindergarten through 12<sup>th</sup> grade (TK/K-12);
- (Or advancement to) 7<sup>th</sup> grade.

1. **Complete the pupil's identification section.** The Statewide Student Identifier (SSID) is a 10-digit number assigned to TK/K-12 public school pupils by the California Department of Education.
2. **Complete the vaccine and dose section** using information from the pupil's immunization record provided by a parent or guardian, prior school, or an immunization registry.
  - a. Record the date (month/day/year) of each dose the pupil has received, even if the pupil has an exemption to one or more required vaccines. Any vaccine given four or fewer days prior to the minimum required age is valid.
  - b. Check the Permanent Medical Exemption (PME) box(es) for vaccines that are permanently exempt for medical reasons. If all vaccines are exempted, then fill in the date for "Date Requirements Met" in the appropriate row in the Status of Requirements section. This date is usually the date records are determined to be complete. File the medical exemption form specifying the exempted immunization(s) in the pupil's record.
3. **Complete the appropriate row in the Status of Requirements section.**
  - a. Enter the initials of the staff reviewing the pupil's record.
  - b. If the pupil meets admission requirements, check the designated box and enter the date under "Date Requirements Met." This date is usually the date records are determined to be complete.
  - c. If the pupil does not have all required doses but is not due for any doses at the time of admission, check the "Missing Doses Not Currently Due—Conditional" box and fill in the "Follow-up Date(s)" space. Review records at least every 30 days. Once the pupil meets all admission requirements, fill in the date for "Date Requirements Met."
  - d. If the pupil has a Temporary Medical Exemption, check the designated box and write the expiration date in the "Follow-up Date(s)" space. Once the pupil meets all admission requirements, fill in the date for the "Date Requirements Met."
  - e. If the pupil is due for doses and subject to exclusion, check the "Missing Doses Are Overdue—Needs Doses Now" box and fill in the "Follow-up Date(s)" space.

- f. If the pupil does not have all required immunizations and does not meet criteria for conditional admission (including a temporary medical exemption) and is:

- **IEP:** Accessing special education services required by the pupil's individualized education program, or
- **IND:** Enrolled in an independent study program and does not receive classroom-based instruction, or
- **Home:** Enrolled in a home-based private school

Then, using the codes above, check the appropriate box under "Other" and fill in the date for "Date Requirements Met."

### Maintain a roster of all pupils who are unimmunized for immediate identification in case of disease outbreak or exposure in the community.

#### TRANSFER PUPILS

**Transferring from a school in-state or another state:** Review the immunization information and supporting documentation for exemptions included in the pupil's record or other immunization record, verifying the pupil has met immunization requirements for the pupil's age/grade. If the pupil has a Permanent Medical Exemption (PME), then add the pupil's name to your facility's roster of unimmunized pupils.

**Transferring from your school:** Provide this form or an equivalent immunization record as specified in 17 CCR section 6070(b) and any exemption documentation as part of the pupil's record.

If a pupil transfers from one school to another within California, the pupil's record shall be transferred by the former school no later than 10 school days following the date of request from the school where the pupil intends to enroll (California Education Code section 49068).

**Foster children:** California law requires schools to immediately enroll foster children transferring to their school even if the child is unable to produce immunization records normally required for school entry. Within two business days of the foster child's request for enrollment, the educational liaison for the new school shall contact the school last attended to obtain all records. The educational liaison for the school last attended shall provide all records to the new school within two business days of receiving the request (California Education Code section 48853.5(f)(8)(C)).

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department's information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.

## AFFIDAVIT REGARDING LIABILITY INSURANCE FOR FAMILY CHILD CARE HOME

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**SECTION A:**

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I/We, the parent(s)/guardian(s) of \_\_\_\_\_,  
(Child's Name)

acknowledge that \_\_\_\_\_,  
(Licensee's Name)

the licensee of \_\_\_\_\_,  
(Name of Family Child Care Home)

has informed me/us that this facility does not carry liability insurance or a bond in accordance with standards established by Family Child Care statute.

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**SECTION B: To be completed only if licensee does not own premises or the licensee is a member of a condominium or Homeowner's Association.**

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I/We, the parent(s)/guardian(s) of \_\_\_\_\_,  
(Child's Name)

acknowledge that \_\_\_\_\_,  
(Licensee's Name)

the licensee of \_\_\_\_\_,  
(Name of Family Child Care Home)

has informed me/us that she/he does not own the premises or is a member of a condominium or Homeowner's Association, and the liability insurance, if any, of the owner/Homeowners' Association may not provide coverage for losses arising out of, or in connection with, the operation of the family child care home, except to the extent that the losses are caused by, or result from, an action or omission by the owner/Homeowners' Association, for which the owner/Homeowners' Association would otherwise be liable under the law.

\_\_\_\_\_  
Signature of Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

**NOTE:** The law requires Family Child Care providers to carry liability insurance or bond in the amount of \$300,000 annually or to maintain this signed statement in the facility file. Lack of a bond or insurance does not effect the right of parents to bring legal action against the facility.

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO PROVIDE 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 WHATEVER  
NAME

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

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE  
(CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

# 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: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

Date This Form Completed: \_\_\_\_\_

Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

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**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.

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

## PARENT NOTIFICATION ADDITIONAL CHILDREN IN CARE

As required by Health and Safety Code Sections 1597.44(c) and 1597.465(c), you are hereby notified that: *(Check one)*

I am licensed as a Small Family Child Care Home and may provide care for more than six and up to eight children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than two infants are in care.

I am licensed as a Large Family Child Care Home, and with an assistant provider, may provide care for more than 12 and up to 14 children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than three infants are in care.

\_\_\_\_\_  
(PRINT FACILITY ADDRESS)

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(CUT ALONG DOTTED LINE)

### RECEIPT OF PARENT NOTIFICATION (Facility Copy) Additional Children in Care

I, \_\_\_\_\_, acknowledge receipt of the notification that this Small Family Child Care Home may be providing care for more than six and up to eight children, or that this Large Family Child Care Home may be providing care for more than 12 and up to 14 children in accordance with Health and Safety Code Sections 1597.44 and 1597.465.

\_\_\_\_\_  
(PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(CHILD'S NAME)

**Maintain the completed and signed bottom half of this form in the child's record  
and provide the completed top half of this form to the child's parent or authorized representative.**

**NEBULIZER CARE CONSENT/VERIFICATION  
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, \_\_\_\_\_, give my consent for \_\_\_\_\_,  
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at \_\_\_\_\_,  
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, \_\_\_\_\_, and to contact my child's health care  
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

## FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION

***Family Child Care (FCC) is provided by the home of a licensed provider for up to eight children with one adult or up to 14 children with one adult and one assistant. FCC homes provide a home like setting. Making sure that the licensed FCC homes are providing safe care is the job of the licensing agency, the parents and the provider.***

### HEALTH and SAFETY CHECKLIST

You should check for basic health and safety practices in the home. Your FCC Provider, by state law and regulation, must do the following:

- Get a license from the local licensing agency.
- Provide care to no more than eight children (with no more than two children under age 2) or 14 children with an assistant (with no more than 3 children under age 2).
- Make sure the home has heat in cold weather and is cool in hot weather.
- Keep detergents and cleaning products out of children's reach.
- Make sure swimming pools are fenced or have a pool cover.
- Baby gates must block stairs in facilities when children less than five years old are in care.
- Store guns, other weapons, and poisons in locked areas.
- Have an emergency plan in case of fire or earthquake.
- Keep an emergency information card on every child in care.
- Keep a fire extinguisher and working smoke alarm in the FCC home.
- Provide a smoke free environment.
- Not use baby walkers, bouncers or similar items.

### WHAT SHOULD THE FAMILY CHILD CARE HOME PROVIDE?

**You should** get answers to these questions before placing your child in the home:

- Is the home clean and safe?
- Are there enough toys and games?
- How will my child be disciplined? (**Spanking, hitting, slapping, shaking and so forth are not permitted in licensed homes.**)
- What meals will my child be given?
- How will the food I bring be stored and prepared?
- Is there enough room (*indoor and outdoor*) for my child to play?
- What activities are planned for my child?
- How will my child be cared for when he or she gets sick?
- How many other children will be in care?
- What ages are the other children?
- What are the sleeping/napping/rest arrangements?
- How will I find out if my child is hurt or injured while in care?

### DISCUSS THE FOLLOWING WITH THE PROVIDER:

- **Setting times** for arrival and pickup.
- **Bringing items** from home (*food, toys, change of diapers, change of clothes, toothbrush, infant furniture, and so forth*).
- **Providing instructions** for giving medicines or special food.
- **Providing telephone numbers** for home, work, spouse's work, doctor and neighbor.
- **Providing a list of names** and telephone numbers of people who may pick up your child.

### GOOD CHILD CARE INCLUDES THESE THINGS:

- **A provider** who provides warm and loving care and guidance for your child, and who works with you and your family to make sure your child grows and learns in the best way possible.
- **A home** that keeps your child safe, secure, and healthy.
- **Activities** that help your child grow mentally, physically, socially and emotionally.
- **Your involvement** in your child's care.

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## WHAT ARE PARENTS' RESPONSIBILITIES?

*The California Department of Social Services licenses homes to provide child care, and wants you to understand the licensing laws and the ways in which you can check the quality of care your child receives.*

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### WHAT SHOULD PARENTS DO?

- **Ask** to see the FCC home license. Homes caring for children from more than one family must be licensed.
- **Check** the condition of the FCC home frequently. Parents have the legal right to "drop in" at any time care is being provided.
- **Know** your rights as a parent by reading and keeping the Notification of Parents' Rights form.
- **Make sure** the Parents' Rights Poster is displayed in the home.
- **Watch** how your child acts in the home.
- **Listen** to what your child tells you about the care received in the home.
- **Talk** with the provider about any problems. Inform the provider of anything in the home which could hurt your child.
- **Call or write** the licensing agency if the provider fails to fix a hazard or if you believe your child has been harmed while in the provider's care. (See "How to file a complaint")
- **Ask** to see the licensing reports on file in the home.
- **Call or visit** the licensing office and ask to look at your provider's licensing file
- **Ask** if there are any adults in the home that have a criminal background.

### PARENTS OF BABIES SHOULD ENSURE THAT:

- The baby receives **good nutrition** and is fed at the proper times.
- **A stimulating environment** is provided.
- The provider gives **emotional support**, and holds the child regularly.
- The provider cares for **no more than four babies**.
- Babies are **placed on their backs** when put down to sleep or nap.

### HOW TO FILE A COMPLAINT ABOUT A FAMILY CHILD CARE HOME

#### COMPLAINT PROCESS

1. If you think a FCC provider is breaking the licensing laws, you may file a complaint with the local licensing office. You can find the address and telephone number in the following ways:
  - the provider's license
  - your copy of the Parents' Rights Notification form
  - the telephone book under:

**STATE OF CALIFORNIA  
DEPARTMENT OF SOCIAL SERVICES  
COMMUNITY CARE LICENSING**

OR

**COUNTY OF \_\_\_\_\_  
WELFARE OR SOCIAL SERVICES DEPARTMENT  
CHILD CARE LICENSING**

- The California Department of Social Services Community Care Licensing Division's website at [www.cclid.ca.gov](http://www.cclid.ca.gov)
2. Call or write your local licensing office and explain your complaint. Your name will remain anonymous unless you give us permission to use it. You will be notified of the results when the investigation is done.
  3. If you believe your child is being physically or sexually abused, you should also report it to your local Police Department or Sheriff's Department.
  4. Contact the local licensing office about any issues or questions you may have.
  5. To learn more about the Child Care Licensing program and services, please visit our website. There you will find child care licensing updates, regulations, and information about the child care advocate program.

***WHEN YOU REPORT SUSPECTED VIOLATIONS YOU NOT ONLY PROTECT YOUR CHILD BUT ALSO PERFORM A SERVICE TO YOUR COMMUNITY.***

### WHAT THE LICENSING AGENCY DOES

- Visits each FCC home before issuing a license to operate.
- Does criminal background checks and child abuse index checks on all adults in the home.
- Requires tuberculosis (TB) tests of providers.
- Investigates complaints.
- Makes unannounced visits to the FCC home.
- Denies applications and revokes licenses when necessary.

**BLOOD GLUCOSE TESTING CONSENT/VERIFICATION  
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.797 before a child care licensee or staff person performs blood glucose testing on a child in care diagnosed with diabetes. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who performs blood glucose testing on the child.***

I, \_\_\_\_\_, give my consent for \_\_\_\_\_,  
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at \_\_\_\_\_,  
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to perform blood glucose testing on my child, \_\_\_\_\_, and to contact my child's health  
care provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to perform blood glucose testing on my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- The blood glucose test must be approved by the Federal Food and Drug Administration.
- Specific written directions for performing blood glucose testing in accordance with the physician's prescription.
- Potential side effects and expected response.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

# INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: \_\_\_\_\_

## SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date
Authorized Representative's Name (Primary Contact)		Phone Number
Authorized Representative's Name (Secondary Contact)		Phone Number

## SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in: <input type="checkbox"/> Crib <input type="checkbox"/> Play Yard <input type="checkbox"/> Other (Specify) _____	What are the Infant's usual sleeping hours? _____ _____
What is the infant's average length of the Infant's nap(s) during the day time? _____ minutes    _____ hours	Does the infant use a pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If <b>yes</b> , brand: _____

## SECTION C: INFANT'S ABILITY TO ROLL

My child, \_\_\_\_\_ is able to roll from their back to their stomach and stomach to their back beginning \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

Authorized Representative Signature	Date
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## SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date
Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

**SECTION E: MEDICAL EXEMPTION**

Does the infant have a medical exemption?  Yes  No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

**I certify that all information contained in this form is complete and accurate to the best of my ability.**

Authorized Representative Signature

Date



## EFFECTS OF LEAD EXPOSURE

Children 1-6 years old are the most at risk for lead poisoning.

- Lead poisoning can harm a child's nervous system and brain when they are still forming, causing learning and behavior problems that may last a lifetime.
- Lead can lead to a low blood count (anemia).
- Even small amounts of lead in the body can make it hard for children to learn, pay attention, and succeed in school.
- Higher amounts of lead exposure can damage the nervous system, kidneys, and other major organs. Very high exposure can lead to seizures or death.

## LEAD POISONING FACTS

- Buildup of lead in the body is referred to as lead poisoning.
- Lead is a naturally occurring metal that has been used in many products and is harmful to the human body.
- There is no known safe level of lead in the body.
- Small amounts of lead in the body can cause lifelong learning and behavior problems.
- Lead poisoning is one of the most common environmental illnesses in California children.
- The United States has taken many steps to remove sources of lead, but lead is still around us.

### IN THE US:

- Lead in house paint was severely reduced in 1978.
- Lead solder in food cans was banned in the 1980s.
- Lead in gasoline was removed in the early 1990s.



## LEAD IN TAP WATER

The only way to know if tap water has lead is to have it tested.



Tap water is more likely to have lead if:

- Plumbing materials, including fixtures, solder (used for joining metals), or service lines have lead in them.
- Water does not come from a public water system (e.g., a private well).

To reduce any potential exposure to lead in tap water:

- **Flush the pipes in your home**  
Let water run at least 30 seconds before using it for cooking, drinking, or baby formula (if used). If water has not been used for 6 hours or longer, let water run until it feels cold (1 to 5 minutes.)\*
- **Use only cold tap water for cooking, drinking, or baby formula (if used)**  
If water needs to be heated, use cold water and heat on stove or in microwave.
- **Care for your plumbing**  
Lead solder should not be used for plumbing work. Periodically remove faucet strainers and run water for 3-5 minutes.\*

- **Filter your water**

Consider using a water filter certified to remove lead.

**WARNING!** Some water crocks have lead. Do not give a child water from a water crock unless you know the crock does not have lead.



(\*Water saving tip: Collect your running water and use it to water plants not intended for eating.)

- For information on testing your water for lead, visit the Environmental Protection Agency at their [website](#) or call (800) 426-4791. You can also visit the California Department of Public Health's website at [www.cdph.ca.gov](http://www.cdph.ca.gov).



## POTENTIAL SOURCES OF LEAD

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- Old paint, especially if it is chipped or peeling or if the home has been recently repaired or remodeled
- House dust
- Soil
- Some imported dishes, pots and water crocks. Some older dishware, especially if it is cracked, chipped, or worn
- Work clothes and shoes worn if working with lead
- Some food, candies and spices from other countries
- Some jewelry, toys, and other consumer products
- Some traditional home remedies and traditional make-up
- Lead fishing weights and lead bullets
- Water, especially if plumbing materials contain lead

## SYMPTOMS OF LEAD EXPOSURE

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Most children who have lead poisoning do not look or act sick. Symptoms, if any, may be confused with common childhood complaints such as

stomachache, crankiness, headaches, or loss of appetite.



A blood lead test is free if you have Medi-Cal or if you are in the Child Health and Disability Prevention Program (CHDP). Children on Medi-Cal, CHDP, Head Start, WIC, or at risk for lead poisoning, should be tested at age 1 and 2. Health insurance plans also will pay for this test. Ask your child's doctor about blood lead testing.

For more information, go to the California Childhood Lead Poisoning Prevention Branch's [website](#), or call them at (510) 620-5600.

The information and images found on this publication are adapted from the California Department of Public Health Childhood Lead Poisoning Prevention Program.

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