

Modoc Child Care Resource & Referral  
Subsidized child care enrollment CHECK LIST

- Intake Form
- Enrollment packet
- Proof of need (one option below)
  - Employment verification form
  - Incapacitation form (signed by doctor)
  - Education enrollment form
  - Self employment form
- Income verification-last pay stub
- Birth Certificates of every child in Household
- Immunization Records
- Proof of Residency (Any bill with your physical address and name on it or rental agreement)

Modoc Child Care Resource and Referral  
A Division of T.E.A.C.H., Inc.  
112 East 2<sup>nd</sup> Street \* Alturas, CA 96101  
(530) 233-5437 \* Fax (530) 233-4744  
Toll Free 1-866-571-9703

Dear Parent/Guardian:

First, we would like to take this opportunity to say welcome to our program. We are very pleased that we can help you with your childcare needs. If we work together this will be a rewarding experience for all involved. There are a few program rules that **MUST** be followed to ensure your childcare is paid for in a timely manner and to ensure your childcare will continue uninterrupted. These rules are as follows:

1. Always notify this office within **(5)** days of any changes in your household or income. If you are unsure we need to be notified, contact your Program Specialist and notify anyway. Failing to notify us of changes is grounds for termination from the program. When in doubt, notify!
2. If you receive a NOA (Notice of Action) do NOT ignore it. These are generated when there are changes we have made to your file or we are requesting documentation or information. Look these over and make sure all information is correct and provide the information being requested. If you disagree with the NOA this is your opportunity to file an appeal.

This is not a complete list, however these are the rules that many families overlook. Please read your handbook thoroughly for all the program policies and rules. Thank you for taking the time to become familiar with our program and we look forward to being able to serve you in a consistent, reliable manner. If you have any questions or concerns please contact your caseworker.

Sondra Ramsey

Program Specialist II

Modoc child Care Resource & Referral  
112 East 2<sup>nd</sup> Street  
Alturas, CA 96101  
(530) 233-5437 Fax 233-4744

Parent Fee Policy and Information: The fee will be for the duration of the new income or for services that may have been provided when the family was not eligible. MCCR&R may terminate the family due to non-notification.

1. Parent Fees are listed on the front page of the Parent and Provider Agreement. In addition the parent is told about the fee during the application process.
2. Parent Fees are paid directly to your child care provider.
3. A part-time Parent Fee is based on care that is less than six hours per day, while full time care is enrollment for six or more hours per day. If a parent uses more hours than indicated on the agreement, the parent fee amount may be higher if the additional hours are going to be paid for by the subsidized child care program.
4. If a school-aged child needs full time care due to illness, school holiday, or in-service day, the rate of the parent fee becomes full time *if* the additional hours are going to be paid for by the subsidized child care program.
5. If your provider charges for holidays and your child does not attend, the parent fee must be paid *if* the hours are charged to the program. A **Best Interest Day** will be applied for that day of absence.
6. Fees should be collected in advance by the provider and in accordance with the provider's policies. It is up to the parent and provider to determine how often payments should be made; fees may be paid once a week, twice a month, once a month, or even daily, depending on the arrangements between the provider and the parent.
7. If the parent fails to pay the fee, the provider may refuse to provide care. In addition, the parent will be dropped from the program if fees are more than 14 days late. Providers need to notify MCCR&R when parents fail to pay their parent fees.
8. When MCCR&R is notified by the provider of a parent's failure to pay a Parent Fee a NOTICE OF ACTION (NOA) will be issued terminating child care services. The effective date for termination is 14 days from the date the Notice was issued if payment is not made. The Notice will state the amount of unpaid fees, the fee rate, and the period of delinquency. However, if a reasonable plan for payment of delinquent fees is arranged prior to the effective date of the NOA between the parent and the provider, child care services will continue to be provide to the child as long as the parent pays all current fees when due and complies with provisions of the repayment plan.
9. If MCCR&R issues **three Notice of Actions for delinquent fees within a twelve month period, we will terminate services for general program abuse.** Upon termination of services for non-payment of delinquent Parent Fees, the family may be placed on the Waiting List for services. The family, however, will not be eligible for the Subsidized Child Care Payment Program until all delinquent fees are paid to the provider. At such time the family will be re-enrolled according to CDE enrollment priorities.
10. If a parent pays child care fees to another provider at any time during the month, these fees may be deducted from the Parent Fee for the next billing period. The parent must document other child care costs by providing a written receipt from the provider indicating the amount paid, the date, and the period of service provided. Amounts deducted from the Parent Fee can not exceed the total Parent Fee for the month in which the child care fees have been paid, not can the amount exceed the 1.5 standard deviations of mean market rate for child care. Fee credit shall not be given for Share of Child Care Costs. Parent Feed are based on the child's enrollment schedule and are **not adjusted for absences** unless pre-approved and the child care provider will not be charging for child care during the absence.
11. The amount due is deducted from the provider check, whether it is paid in full by the parent or not. In order to receive full reimbursement for child care, the provider needs to collect the Parent Fee amount directly from the parent.
12. Each month the provider needs to complete a receipt on a Parent Fee Payment Form. The form is in triplicate and the provider needs to return the white copy to MCCR&R along with the Attendance Sheet Certificates. The yellow copy is given to the parents and the pink copy is for the provider's records.

I have reviewed and I understand the above policy regarding payment of my Parent Fee.

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PARENT SIGNATURE

---

DATE

# Family Needs Assessment

Parent's Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Do you have any concerns about your child/ren in any of the following areas:

- |                                 |                                |                                |                                 |                                |                            |
|---------------------------------|--------------------------------|--------------------------------|---------------------------------|--------------------------------|----------------------------|
| YES<br><input type="checkbox"/> | NO<br><input type="checkbox"/> | Hearing                        | YES<br><input type="checkbox"/> | NO<br><input type="checkbox"/> | Learning/Brain Development |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Vision                         | <input type="checkbox"/>        | <input type="checkbox"/>       | Social Development         |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Speech                         | <input type="checkbox"/>        | <input type="checkbox"/>       | Physical Development       |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Behavior/Emotional Development |                                 |                                |                            |

Has your child care provider indicated any concerns in the areas listed above?

Please Explain: \_\_\_\_\_

Are you currently receiving services for any areas marked "yes"? \_\_\_\_\_

Is a language other than English spoken in the home? If so, what \_\_\_\_\_

Would you like information or referrals for:

- |                                 |                                |                      |                                 |                                |                                 |
|---------------------------------|--------------------------------|----------------------|---------------------------------|--------------------------------|---------------------------------|
| YES<br><input type="checkbox"/> | NO<br><input type="checkbox"/> | Financial Assistance | YES<br><input type="checkbox"/> | NO<br><input type="checkbox"/> | Domestic Violence Counseling    |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Food Assistance      | <input type="checkbox"/>        | <input type="checkbox"/>       | Legal Assistance                |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Housing              | <input type="checkbox"/>        | <input type="checkbox"/>       | Family Counseling               |
| <input type="checkbox"/>        | <input type="checkbox"/>       | Nutrition            | <input type="checkbox"/>        | <input type="checkbox"/>       | Parenting Education/Information |

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Referrals Given: \_\_\_\_\_

**PARENT AND COMMUNITY MEMBER  
EVALUATION AND PLANNING SURVEY**

**MODOC CHILD CARE RESOURCE & REFERRAL**

A Division of T.E.A.C.H., Inc.  
112 East 2<sup>nd</sup> Street  
Alturas, CA 96101

(530) 233-5437 Fax (530) 233-4744

Dear Parent/Community Member:

In order to evaluate our services to parents and child care providers, and plan for the years to come, we need feedback from you! In this way we can be sure that we will continue to meet your needs. Please take a few minutes to complete this survey and return to us. We look forward to hearing from you.

DATE: \_\_\_\_\_

**A. ABOUT YOU: (PLEASE CHECK ALL THAT APPLY)**

**1. I am a:**

- |   |   |
|---|---|
| <input type="checkbox"/> Parent                           | <input type="checkbox"/> Center Director        |
| <input type="checkbox"/> Licensed Child Care Provider     | <input type="checkbox"/> Community Member       |
| <input type="checkbox"/> Non-Licensed Child Care Provider | <input type="checkbox"/> Other (Identify) _____ |

**2. I used these Modoc Child Care Resource & Referral Collaborative Services**

(Check all that apply).

- |   |  |
|---|--|
| <input type="checkbox"/> Child Care Referrals             | <input type="checkbox"/> Toy and Resource Lending Library  |
| <input type="checkbox"/> Referrals to Community Resources | <input type="checkbox"/> Technical Assistance              |
| <input type="checkbox"/> Subsidized Child Care Program    | <input type="checkbox"/> Child Care Brochures              |
| <input type="checkbox"/> Children's Fair                  | <input type="checkbox"/> Morning in the Park (0-5 years)   |
| <input type="checkbox"/> CPR/1 <sup>ST</sup> Aid Training | <input type="checkbox"/> Child Care Licensing Orientations |
| <input type="checkbox"/> Health & Safety Training         | <input type="checkbox"/> Modoc Messages Newsletter         |
| <input type="checkbox"/> Workshops/Other Trainings        | <input type="checkbox"/> Car Seat Loan Program             |
| <input type="checkbox"/> Car Seat Purchase Program        | Other (please explain) _____                               |

**B. CHILD CARE REFERRAL SERVICES:**

**1. When calling MCCR&R I usually reach someone:**

- |  |  |
|--|--|
| <input type="checkbox"/> On the 1 <sup>st</sup> call | <input type="checkbox"/> My call was returned  |
| <input type="checkbox"/> Leave a message             | <input type="checkbox"/> Other (Explain) _____ |
- \_\_\_\_\_

**2. Was the MCCR&R employee you spoke with professional and courteous?**

Yes  No Please explain \_\_\_\_\_

**3. I was able to obtain the information I needed.  Yes  No**

Please explain \_\_\_\_\_

**4. If the MCCR&R employee did not have the information you needed did she refer you to someone or an agency that could help you?**

Please explain \_\_\_\_\_

**5. Please indicate the types of workshops or trainings that you might want our agency to offer in the future. Please check the topics that most interest you.**

- |   |  |
|---|--|
| <input type="checkbox"/> Effective discipline techniques                                    | <input type="checkbox"/> Parenting subjects                  |
| <input type="checkbox"/> Business income tax preparation for licensed and exempt child care | <input type="checkbox"/> Earthquake preparedness             |
| <input type="checkbox"/> Children's crafts  | <input type="checkbox"/> Lead poisoning                      |
| <input type="checkbox"/> Immunization requirements/documentation                            | <input type="checkbox"/> Serving children with special needs |
| <input type="checkbox"/> Other suggestions (describe) _____                                 |  |

**C. EVALUATION OF OVERALL PROGRAM**

**1. Please rate our services overall**

Excellent  Good  Average  Poor

**Additional comments (if you mark Average or Poor, please give reasons here, thanks!)**

\_\_\_\_\_

**2. Suggestions for new/expanded MCCR&R services/activities and improvement of existing services (please include your comments on the Modoc Messages Newsletter and other publications.)**

\_\_\_\_\_

**MEMORANDUM OF UNDERSTANDING**

**Parent Reporting Checklist**

The California Department of Education, Child Development Division requires Modoc Child Care Resource & Referral (MCCR&R) to inform families receiving funds from the State and Federal Subsidized Child Care Programs that if your child care funds are obtained by providing fraudulent, false, or incomplete information, MCCR&R will actively pursue recovering funds paid out for the child care services. Any fraudulent, false, or misleading information provided to MCCR&R regarding your employment, income, status as a student, family size, or your eligibility relating to medical incapacitation will be **grounds for termination** and will be cause for MCCR&R to recover the funds.

**GROUND FOR TERMINATION ARE AS FOLLOWS:**

**Please read and initial each section:**

Failure to report information or changes regarding income, wages, (including commission checks, overtime checks, bonuses, raises or pay cuts), school loans or grants (not issued or insured by State or Federal Agencies), SSI/SSP, child support, and other income received which is needed to document eligibility and parent fees. All income changes just be reported within five (5) days. **If you have any questions regarding reporting a particular type of income, please ask your program specialist.**

\_\_\_\_\_ Failure to report loss of employment within five (5) days of your last day of employment.

\_\_\_\_\_ Failure to report any change in employment such as a new job, temporary lay off and/or medical leave within five (5) days.

\_\_\_\_\_ Failure to report change in family size within five (5) days. This includes marriage of, father or mother of child living in the household (when family size changes, your need for child care may change, and/or your income may change, affecting your eligibility and/or parent fee).

\_\_\_\_\_ All documents supplied to MCCR&R regarding any of the other adults in the household also must be complete and true.

\_\_\_\_\_ If MCCR&R pays for child care due to your enrollment in a school or training program and you fail to report dropped classes or changes in you school hours within five (5) days.

\_\_\_\_\_ If the provider states that they provide child care while you were at work or participating in the activity listed on your application when in fact they did not provide services at those designated times and both the provider and parent signs the attendance sheet stating the child was in care, or signed the form knowing that someone else other than the contracted provider provided the care, MCCR&R will recover the funds from the parent for child care services (the hours recorded on the attendance sheet must be while the parent is in training, actively seeking work, attending classes or working contracted hours with the employer listed on the application). If the child is absent, the reason for the absence must be written on the attendance sheet and signed by the parent.

\_\_\_\_\_ If you are terminated for any of the above reasons and you file for a fair hearing (appeal) and you lose, you will have to pay back any money that MCCR&R paid during your enrollment on any of our programs.

\_\_\_\_\_ MCCR&R will attempt to recover funds by developing a repayment plan with the parent. If the parent does not respond to the repayment plan or misses the payment as outlined in the repayment plan, a claim will be filed with Small Claims Court. If the parent still refuses to pay the claim, the claim will be referred to the District Attorney's Office.

\_\_\_\_\_ I understand that I may be required to submit a copy of my employer's time cards or time sheets for an entire month at any given time. Upon request, this information must be submitted with the appropriate month's attendance sheets within five (5) days or I may be terminated from the program and I will be responsible for any child care costs paid on my behalf.

I the undersigned parent/guardian have read and understand the conditions outlined by Modoc Child Care Resource and Referral Parent and Provider Handbook. I have also read and initialed the information on the Memorandum of Understanding, Parent Reporting Check List and understand that failure to provide or report information regarding my eligibility and/or providing false, fraudulent, and misleading information will not only result in termination from MCCR&R's Subsidized Child Care Program, but will also result in my having to payback MCCR&R for my children's child care costs.

**Please note that this form and all other required paper work has to be completed and signed before child care will be covered.**

\_\_\_\_\_ **Print Name**

\_\_\_\_\_ **Parent/Guardian Signature**

\_\_\_\_\_ **Date**

\_\_\_\_\_ **MCCR&R Staff Signature**

\_\_\_\_\_ **Date**

## FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS

### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home 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 family child care home, 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 family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. **(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).**
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Calif. Dept. of Social Services, Community Care Licensing

Licensing Office Address: 520 Cohasset Rd. Suite #6, Chico, CA 95926

Licensing Office Telephone #: (530) 895-5033

8. Be informed by the licensee, upon request, of the name and type of association to the family child care home 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.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

**NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME 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 995A (12/06)

(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 "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee. \_\_\_\_\_

Name of Family Child Care Home

Signature (Parent/Authorized Representative) \_\_\_\_\_ Date \_\_\_\_\_

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.**

**For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)**

LIC 995A (12/06)

### Emergency and Identification Information

#### I. Family Information

Child's name (Last, First, Middle): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Father's name: \_\_\_\_\_

Child's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's business address: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's business address: \_\_\_\_\_ Phone: \_\_\_\_\_

#### II. Names of Persons Authorized to Take Child from the Facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

Name	Telephone	Relationship
_____	_____	_____
_____	_____	_____

#### III. Additional Persons Who May Be Called in an Emergency to Take Child from the Facility

Name	Address	Telephone	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

#### IV. Physician to Be Called in an Emergency

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

V. Medi-Cal Number \_\_\_\_\_ Medical Insurance \_\_\_\_\_  
Insurance Number \_\_\_\_\_

VI. Allergies or Other Medical Limitations \_\_\_\_\_

**VII. Permission for Medical Treatment Administrative** procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

*In case of an accident or an emergency, I authorize a staff member of the child development agency to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian



### 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?
	LUNCH	BREAKFAST _____
	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*
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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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### 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	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES? \_\_\_\_\_ ANY EATING PROBLEMS? \_\_\_\_\_

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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