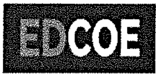

EL DORADO COUNTY OFFICE OF EDUCATION

## EL DORADO COUNTY OFFICE OF EDUCATION // CHILD DEVELOPMENT PROGRAMS

**EARLY HEAD START / HEAD START / STATE PRESCHOOL**

**Child's Name** ______________________________ **Birthdate:** ____________________

***WELCOME*** to the El Dorado County Office of Education, Child Development Programs.
In order for us to efficiently process your application for enrollment in the Child Development Programs, please complete the enclosed application packet and attach the following documentation when submitting your application. All documentation is required to complete an application and be considered for enrollment:

- ☐ Birth certificate
- ☐ Birth certificates for other children in the family
- ☐ Current immunizations
- ☐ Family or child's medical card
- ☐ Income verification (paycheck stub, etc.) for one **full** month, *not required for fee paying families*
- ☐ Single parent status verification
- ☐ IEP/IFSP (If applicable)

☞ *All children accepted into program will require proof of a current physical exam or have one completed within 30 days of starting program.*

If you are applying for a Head Start or State Preschool classroom, please indicate your top three choices below:

### CHILD DEVELOPMENT PROGRAM HEAD START and STATE PRESCHOOL SITES (3 and 4 year old children)

_____ **Al Tahoe** Head Start/State Preschool
_____ **Blue Oak** State Preschool
_____ **Brooks** State Preschool
_____ **Buckeye** Head Start/State Preschool
_____ **Camino** Head Start/State Preschool
_____ **Camerado Springs** Head Start/State Preschool
_____ **Charles Brown** Head Start/State Preschool
_____ **Georgetown** Head Start/State Preschool
_____ **Gold Oak** Head Start/State Preschool
_____ **Green Valley** State Preschool
_____ **Home Based** Head Start
_____ **Jackson** State Preschool
_____ **Ken Lowry** Head Start/State Preschool
_____ **Pinewood** Head Start/State Preschool
_____ **Placerville** Head Start/State Preschool
_____ **Rescue** Head Start/State Preschool
_____ **Sutter's Mill** State Preschool
_____ **Tahoe** Head Start/State Preschool
_____ **Valley View Montessori** State Preschool

***How did you hear about our program?***
☐ Friend/Family ☐ EDCOE Website ☐ Newspaper/Advertisement ☐ Facebook ☐ Other ______________

***FOR OFFICE USE ONLY*** *Date Application Received* ______________ *Staff Initials* __________

☐ Application is **COMPLETE**. More information regarding enrollment to follow.

☐ Application is **NOT COMPLETE**. Please submit the missing/incomplete items highlighted above. See notes below.

El Dorado County Office of Education Child Development Programs
6767 Green Valley Road, Placerville, CA 95667 ~ (530) 295-2270 / 295-2276 FAX (530) 626-9511

HEAD START / EARLY HEAD START / STATE PRESCHOOL

| CHILD DEVELOPMENT PROGRAMS | **2018/2019 APPLICATION FOR PROGRAM SERVICES** | Form: M-A-116\1819 |
|---|---|---|

## *Child's Legal Name*

Last First Birthdate Female/Male Social Security Number

**Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other ____________

**Hispanic:** ☐ Yes ☐ No

**Primary Language at home** ☐ English ☐ Spanish ☐ Other:__________

**Parental Status** ☐ One parent ☐ Foster ☐ Two parent ☐ Guardian

**Has your child previously been enrolled in a Child Development Program?** ☐ **Yes** ☐ **No**

**Does your child have a special need, disability or chronic health issue?** ☐ **Yes** ☐ **No**

**Requested Site(s): 1)** ________________ **2)** ________________ **3)** ________________ Fee Base Preschool days requested: M T W TH F

## *Primary Adult*

Last First Birthdate Female/Male Social Security Number

Relationship to Child: ☐ Biological/Adopted/Step ☐ Foster/Guardianship ☐ Aunt/Uncle ☐ Grandparent ☐ Other

Check all that Apply: ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Physical Custody: ☐ Yes ☐ No

Educational Rights: ☐ Yes ☐ No

**Highest Grade Completed:** ☐ Associates ☐ Col/Deg. Training ☐ Grade 10 ☐ Bachelor's ☐ High School Graduate ☐ Grade 11 ☐ Master's ☐ GED ☐ Grade 12 ☐ Col/Adv. Training ☐ < Grade 9

**Employment/Income Status**

☐ Full-time employment (over 35 hrs. week) ☐ Part-time employment (under 35 hrs. week) ☐ Unemployed ☐ **TANF / Supplemental Social Security Income**
☐ Full-time & Training ☐ Part-time & Training ☐ Training or School ☐ Retired or Disabled

**Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian/Pacific Islander ☐ White ☐ Bi-Racial/Multi-Racial ☐ Other ____________

**Hispanic:** ☐ Yes ☐ No

**Food Stamps?** ☐ Yes ☐ No **FS Case #**____________

**WIC?** ☐ Yes ☐ No

**Active Military Service?** ☐ Yes ☐ No **Is at least one parent/guardian a veteran of the US Military?** ☐ Yes ☐No

Cell Phone Number ( ) Okay to Text? ☐ Yes ☐ No Other Phone Number ( ) Type (check one) ☐ Home ☐ Work ☐ Cell ☐ Msg.

## *Secondary Adult*

Last First Birthdate Female/Male Social Security Number

Relationship to Child: ☐ Biological /Adopted/Step ☐ Foster/Guardianship ☐ Aunt/Uncle ☐ Grandparent ☐ Other

Check all that Apply: ☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Physical Custody: ☐ Yes ☐ No

Educational Rights: ☐ Yes ☐ No

**Highest Grade Completed:** ☐ Associates ☐ Col/Deg. Training ☐ Grade 10 ☐ Bachelor's ☐ High School Graduate ☐ Grade 11 ☐ Master's ☐ GED ☐ Grade 12 ☐ Col/Adv. Training ☐ < Grade 9

**Employment/Income Status**

☐ Full-time employment (over 35 hrs. week) ☐ Part-time employment (under 35 hrs. week) ☐ Unemployed ☐ **TANF / Supplemental Social Security Income**
☐ Full-time & Training ☐ Part-time & Training ☐ Training or School ☐ Retired or Disabled

**Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian/Pacific Islander ☐ White ☐ Bi-Racial/Multi-Racial ☐ Other ____________

**Hispanic:** ☐ Yes ☐ No

**Food Stamps?** ☐ Yes ☐ No **FS Case #**____________

**WIC?** ☐ **Yes** ☐ **No**

**Active Military Service?** ☐ Yes ☐ No **Is at least one parent/guardian a veteran of the US Military?** ☐ Yes ☐No

Cell Phone Number ( ) Okay to Text? ☐ Yes ☐ No Other Phone Number ( ) Type (check one) ☐ Home ☐ Work ☐ Cell ☐Msg.

## *Family Information* **Temporary Housing?** ☐ Yes ☐ No

Physical Street Address City State Zip Contact E-Mail Address *(if available)*

Mailing Address *(if different)* City State Zip Contact E-Mail Address *(if different)*

Please list other children or family members living in your household that you are **financially** supporting:

| Name | Race | DOB | Gender | Name | Race | DOB | Gender |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**The above documentation is required to pre-qualify for all Child Development Programs. I certify that, under penalty of perjury, this information is true. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during regular business hours.**

Parent/Guardian Signature:______________________________ Date: ____________

White: Office file Yellow: Site File

# CHILD CARE CENTER
# NOTIFICATION OF PARENTS' RIGHTS

## PARENTS' RIGHTS

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

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 2525 Natomas Park Drive, Suite 250, Sacramento, CA 95833

   Licensing Office Telephone #: (916) 263-5744

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.***



(Detach Here - Give Upper Portion to Parents)

---

## ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

***(Parent/Authorized Representative Signature Required)***

I, the parent/authorized representative of ______________________________, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Child Development Programs
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.***

# PERSONAL RIGHTS

## Child Care Facilities

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Facilities. Each child receiving services from a child care facility 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 facilities, 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
State of California Department of Social Services Community Care Licensing

ADDRESS
2525 Natomas Park Drive, Suite 250

| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
|---|---|---|
| Sacramento | 95833 | (916) 263-5744 |

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) |
|---|---|
| EDCOE Child Development Programs | 6767 Green Valley Road, Placerville, CA 95667 |

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

| (TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | (DATE) |
|---|---|
| | |

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El Dorado County Office of Education Child Development Programs
6767 Green Valley Road, Placerville, CA 95667 (530) 295-2270 // 295-2276 // FAX 626-9511
HEAD START / EARLY HEAD START / STATE PRESCHOOL

| CHILD DEVELOPMENT PROGRAMS | **CHILD PERMISSIONS** | Form: M-A-184 / 1819 |
|---|---|---|

Child's Name: ______________________ Site/Location: ______________

Parent/Guardian Printed Name: ______________________________

I give my permission for the El Dorado County Office of Education, Child Development Programs to:
***(Description of each permission is available on the reverse side.)***

| | | | |
|---|---|---|---|
| 1. | PERMISSION TO ADMINISTER SUNSCREEN | Yes | No |
| 2. | DEVELOPMENTAL ASSESSMENT CONSENT | Yes | No |
| 3. | PHOTOGRAPHS and VIDEO PERMISSION | Yes | No |
| 4. | PHONE NUMBER RELEASE | Yes | No |
| 5. | SCREENING PERMISSION | Yes | No |
| 6. | FLUORIDE TOOTHPASTE | Yes | No |

*MY INITIALS NEXT TO EACH PERMISSION LISTED BELOW, AND MY SIGNATURE AT THE BOTTOM OF THE PAGE INDICATE THAT I ACKNOWLEDGE, HAVE READ AND UNDERSTAND EACH PERMISSION LISTED. ALL PARENT INFORMATION IS KEPT IN STRICT CONFIDENCE WITH THIS AGENCY.*

7. PERMISSION TO TRANSPORT — Initials ________
   The parent/guardian acknowledges that the El Dorado County Office of Education, Child Development Program will transport the child/ren in the event of an emergency or disaster to a safe destination, which will be determined by authorities at the time of evacuation.

8. DEPARTMENT INSPECTION AUTHORITY — Initials ________
   In accordance with section 101200 b & c of the Title 22, Division 12, Chapter 1, Child Care Center Manual of Policies and Procedures, Community Care Licensing: The Department has the authority to interview children or staff, and to inspect and audit child or child care center records, without prior consent. The Department has the authority to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect or inappropriate placement.

9. CHILD ABUSE and NEGLECT REPORTING ACT — Initials ________
   **Section 11165.7 and Section 11166**
   "Any child care custodian who knows or reasonably suspects that a child is or has been a victim of child abuse and/or neglect shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone." "Failure to do so is considered a crime, (Section 11172) since child care custodians are considered mandated reporters." It is important to remember that the primary purpose of the Child Abuse and Neglect Reporting Act is to ***protect the child!*** I understand that the Child Development Programs are mandated child abuse and neglect reporters as indicated by Penal Code, Article 2.5.

______________________________ ______________
Parent/Guardian Signature Date

White: Office File Yellow: Site File Pink: Parent/Guardian

CHILD PERMISSIONS, continued

Explanation of Child Development Program, Child Permissions needed:

1. **PERMISSION TO ADMINISTER SUNSCREEN**

Following the recommendation of the California Department of Health Services, our staff will have available, **Paba Free SPF 30+ Sunscreen** for all children (over 6 months of age) enrolled in the El Dorado County Office of Education, Child Development Programs.

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2. **DEVELOPMENTAL ASSESSMENTS CONSENT**

Parent/guardian gives permission to release the child's assessment results from the Learning Genie and "Desired Results Developmental Profile" (DRDP) for tabulation to produce reports. Birth to three assessments are completed in collaboration with parents. All information is shared on an ongoing basis.

---

3. **PHOTOGRAPHS and VIDEO PERMISSION**

The parent/guardian gives permission for the El Dorado County Office of Education, Child Development Programs to use photographs/or video tapes of the child(ren) for marketing and classroom purposes, including but not limited to child's cubby box, classroom projects, child assessment documentation and portfolios etc. Additional notification will be given to request parent/guardian permission if program intends to use child's photograph for Child Development showcase through newspaper, magazine or internet.

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4. **PHONE NUMBER RELEASE**

The parent/guardian gives permission for the El Dorado County Office of Education, Child Development Programs to release the child's home phone number to Child Development Program parents to be used for program activities only.

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5. **SCREENING PERMISSION**

Child Development programs require that each child have on record some or all of the items below:

1. Developmental screening tools
2. Speech/Language screening
3. Vision screening
4. Hearing screening
5. Height/weight/head circumference
6. Dental screening

The parent/guardian gives permission for the child to have the above screenings completed during the program year. The parent/guardian understands the results from these screenings will be available to the Child Development staff.

---

6. **TOOTHPASTE**

In compliance with Head Start Performance Standard 45 CFR Section 1304.23(b)(3) and recommendations by the American Dental Association, each classroom will have daily tooth brushing. The parent/guardian must indicate whether they want fluoride toothpaste to be used during our daily tooth brushing routine. If the parent/guardian indicates "No" on fluoridated toothpaste, tooth brushing will be done with water.

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6767 Green Valley Road, Placerville, CA 95667 (530) 295-2270 / 295-2276 FAX (530) 295-1935

HEAD START / EARLY HEAD START / STATE PRESCHOOL

| CHILD DEVELOPMENT PROGRAMS | **HEALTH HISTORY** | Form: M-H-211 \\ 1819 |
|---|---|---|

Child's Name ____________ Sex ________ Birthdate ________
Home Phone ____________ Cell Phone ____________ Site/Class ________
Mother's/Guardian Name ____________
Father's/Guardian Name ____________
Child's Current Doctor ____________ ☐ NONE Phone ________
Child's Current Dentist ____________ ☐ NONE Phone ________
Medical Insurance ☐ Medi-Cal ☐ Kaiser ☐ Private ☐ NONE ☐ Other: ________
Foster Child ☐ Yes ☐ No If yes, how long has the child been in your home: ________

## CHILD HEALTH HISTORY

**Does your child have any of the following:**

- * ☐ Yes ☐ No Asthma. If yes, will their inhaler be needed at school? ☐ Yes ☐ No
- * ☐ Yes ☐ No Diabetes
- * ☐ Yes ☐ No Gastrostomy Tube
- ☐ Yes ☐ No Anemia (low blood iron)
- ☐ Yes ☐ No Myringotomy (tubes in ears)
- ☐ Yes ☐ No Hearing Aids
- ☐ Yes ☐ No Vision Problems (squinting, eyes crossed, "lazy eye")
- ☐ Yes ☐ No Eyeglasses prescribed by doctor
- ☐ Yes ☐ No Is your child exposed to tobacco smoke?
- ☐ Yes ☐ No Does your child use mobility equipment (leg brace, walker, or wheelchair). If yes, describe: ________
- * ☐ Yes ☐ No Seizures. If yes, describe: ________
- * ☐ Yes ☐ No Heart Problem. If yes, describe: ________
- ☐ Yes ☐ No Eczema. Other skin condition: ________
- ☐ Yes ☐ No Any major hospitalization/surgery: ________
- ☐ Yes ☐ No Other: ________

**Does your child have any allergies:**

- ☐ Yes ☐ No Seasonal allergies
- * ☐ Yes ☐ No Severe bee sting/insect bite allergy
- * ☐ Yes ☐ No Food allergy. If yes, describe: ________
- * ☐ Yes ☐ No Other allergy: ________
- * ☐ Yes ☐ No My child's allergy requires an EpiPen, or other medication.

**Is your child seeing one of the following specialists:**
☐ Audiologist ☐ Optometrist (eye doctor)
☐ Speech Therapist ☐ Nutritionist
☐ Other: ________

**Has your child ever received services from:**
☐ Alta Regional Center ☐ California Children Services
☐ Mind Institute (UCD) ☐ Special Education
☐ Other: ________

## MEDICATION

- ☐ Yes ☐ No Does your child take any medication? If yes, list: ________
- * ☐ Yes ☐ No Will your child need to take any medication *at school*? If yes, list: ________

## CHILD DENTAL HISTORY

**Has your child been seen by a dentist within the last 12 months?** ☐ Yes ☐ No
Last appointment: ________
Next appointment: ________

- ☐ Yes ☐ No Does your child have any pain or bleeding teeth or gums?
- ☐ Yes ☐ No Does your child take fluoride?
- ☐ Yes ☐ No Does your child drink from a baby bottle?

**What does your child drink?** ________
How often? ________
When? ________

## DEVELOPMENTAL HISTORY

**Was/is your child:**

- ☐ Yes ☐ No Walking by 14 months?
- ☐ Yes ☐ No Using single words by 18 months?
- ☐ Yes ☐ No Toilet trained now?
- ☐ Yes ☐ No Speaking in full sentences now?

**Do you have concerns:**

- ☐ Yes ☐ No About your child's speech?
- ☐ Yes ☐ No About your child's behavior?
- ☐ Yes ☐ No Other developmental concerns: ________

**IEP/IFSP:**
☐ Yes ☐ No Does your child have an IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan)

## PREGNANCY/BIRTH HISTORY

**Please briefly answer the following:**
Were there complications with pregnancy or birth? ________

Did mother use any medications, alcohol, street drugs or tobacco during pregnancy? ________

Was the child born early (premature)? ________

Birth Weight ________ lbs ________ oz

Did the child have any problems at birth or during the first month of life? ________

## SOCIAL HISTORY

**Have you observed the following in your child?**

- ☐ Yes ☐ No Stumbles
- ☐ Yes ☐ No Sucks his/her thumb
- ☐ Yes ☐ No Bites his/her nails

What form of discipline works best with your child? ________

List child's fears or worries: ________

What activities does your child enjoy most? ________

With what adults does your child have frequent contact? ________

How do you comfort your child? ________

Does your child use a special comforting item (e.g. blanket)? ________

Do you have any concerns about your child's emotional health? ________

Has your child witnessed any violence? ________

**Is there anything else you would like us to know about your child?** ________

Office Use Only:

* May require additional paperwork from you doctor.

Signature: ____________ Relationship to child ________ Date ________

Reviewed by: ____________ Title ________ Date ________

White – Office file Canary – Site file

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6767 Green Valley Road, Placerville, CA 95667 ~ (530) 295-2270 / 295-2276 FAX (530) 295-1935

HEAD START / EARLY HEAD START / STATE PRESCHOOL

| CHILD DEVELOPMENT PROGRAMS | **Nutrition Questionnaire – Preschool (3-5yrs.)** | Form: M-H-219 // 1819 |
|---|---|---|

Child's Name ______________________________ Birthdate ______________

Teacher ______________________________ Site/Option ______________

Parent/Guardian Name ______________________________ Phone # ______________

**1. Yes No Is your child on a special diet or allergic to any foods? If yes, what?** ______________

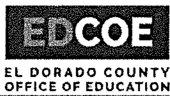
2. Yes No Is your child on WIC? ______________
3. Yes No Is your child taking vitamins, iron or fluoride? If yes, what? ______________
4. How many meals and snacks does your child eat each day? Meals: __________ Snacks: __________
5. Yes No Is your child drinking from a bottle? If yes, how many times a day? ______________
6. Yes No Do you have any questions about the way your child is eating? If yes, what? ______________

Please check the column that shows how often your child eats the following foods. Check only one column for each food.

| Vegetarian: ☐ Yes ☐ No | 2-4 Times a Day | Once Daily | 2-4 Times a Week | Once Weekly | Hardly Ever or Never |
|---|---|---|---|---|---|
| Red Meat: Beef, Pork | | | | | |
| Luncheon Meats, Hot Dogs, Chicken Nuggets (Circle which is served) | | | | | |
| Chicken, Turkey, Fish | | | | | |
| Eggs | | | | | |
| Dried Peas or Beans | | | | | |
| Peanut Butter | | | | | |
| Cereal (dry or cooked) | | | | | |
| 100% Whole Wheat Bread, Tortillas: *circle one* ~ Flour or Corn | | | | | |
| Rice, Noodles | | | | | |
| Milk *Circle One*: Whole 2% 1 % Nonfat Soy Lactaid Other __________ | | | | | |
| Cheese, Yogurt, Sour Cream | | | | | |
| Fruits: Citrus Fruits oranges, pineapple, grapefruit, tangerines, Kiwi, Cantaloupe, Strawberries | | | | | |
| Fruits: Other | | | | | |
| Juices: Citrus (Orange, pineapple, grapefruit) | | | | | |
| Juices: Other | | | | | |
| Vegetables: Tomatoes, Broccoli, Cabbage, Cauliflower, Brussels Sprouts, Peppers | | | | | |
| Vegetables: Other | | | | | |
| Water | | | | | |
| Soda, Fruit-Flavored Drinks | | | | | |
| Chocolate or Strawberry Milk | | | | | |
| Candy, Cakes, Cookies, Donuts | | | | | |
| Pizza | | | | | |
| Potato Chips and Crackers | | | | | |

Parent Signature ______________________________ Date: ______________

White: Site file Yellow: Nutrition Coordinator



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6767 Green Valley Road, Placerville, CA 95667 (530) 295-2270 // 295-2276 // Fax (530) 626-9511
EARLY HEAD START / HEAD START / STATE PRESCHOOL

| CHILD DEVELOPMENT PROGRAMS | **Physical Exam** | Form: M-H-228 \\ 1819 |
|---|---|---|

**Please complete this form and return to: Child Development Programs, Health Coordinator**
**6767 Green Valley Road, Placerville, CA 95667 | PHONE: (530) 295-2270 / 295-2276 or FAX: (530) 295-1935**

CHILD'S NAME: ______________________ DATE OF BIRTH: ______________ ☐ MALE ☐ FEMALE

SITE/CLASS: ______________________ TEACHER: ______________________

* Requirements are based on Bright Futures/American Academy of Pediatrics Periodicity Schedule (Updated February 2017)
** Note: If any section is left blank, this form will be returned to attending Physician/Healthcare Provider for completion.

| * HEIGHT: | * WEIGHT: | * BLOOD PRESSURE: |
|---|---|---|

| * SCREENING OF TB RISK FACTORS * | |
|---|---|
| Are TB Risk Factors Present? ☐ No; TB Skin Test NOT Required<br>☐ Yes; TB Skin Test Required | ☐ Risk Factors PRESENT; TB Skin Test or CXR REQUIRED<br>PPD Date Given: ________ Date Read: ______ ☐ Positive ☐ Negative<br>Chest X-ray Date: __________ ☐ Positive ☐ Negative |

| * HEMOGLOBIN * | * LEAD * |
|---|---|
| ☐ Risk Factors NOT present; Hgb Blood Test NOT Required | ☐ Risk Factors NOT present; Lead Blood Test NOT Required |
| ☐ Risk Factors PRESENT; Hgb Blood Test REQUIRED<br>RESULTS: ________________ (g/dL)<br>Receiving Treatment: ☐ YES ☐ NO Date:____________ | ☐ Risk Factors PRESENT; Lead Blood Test REQUIRED<br>RESULTS: ________________ (μg/dL)<br>Receiving Treatment: ☐ YES ☐ NO Date:____________ |

| * VISION * | * HEARING * |
|---|---|
| LEFT EYE: ☐ Pass ☐ Fail RIGHT EYE: ☐ Pass ☐ Fail | LEFT EAR: ☐ Pass ☐ Fail RIGHT EAR: ☐ Pass ☐ Fail |
| Describe or Check Method Used: ☐ LEA ☐ Sure Sight | Describe or Check Method Used: ☐ OAE ☐ ABR |

| EXAMINATION RESULTS | NORMAL | ABNORMAL | DESCRIBE FINDINGS/COMMENTS |
|---|---|---|---|
| GENERAL APPEARANCE / SKIN | | | |
| HEAD / EARS / EYES / NOSE / THROAT | | | |
| HEART / LUNGS | | | |
| ABDOMEN / GENITOURINARY | | | |
| EXTREMITIES / SKELETAL | | | |
| NEUROLOGICAL (Fine, Gross Motor) | | | |
| SPEECH / LANGUAGE | | | |
| DENTAL ASSESSMENT<br>Dental Referral: ☐ YES ☐ NO | | | |
| NUTRITIONAL ASSESSMENT | | | |
| SOCIAL / BEHAVIORAL ASSESSMENT | | | |
| DEVELOPMENTAL SURVEILLANCE | | | |
| TOBACCO ASSESSMENT<br>Exposed to Secondhand Smoke:<br>☐ YES ☐ NO | | | |
| ALLERGIES (List)<br>Food Allergy: ☐ YES ☐ NO<br>Seasonal: ☐ YES ☐ NO<br>Other: ☐ YES ☐ NO | | | |

**Health Concerns / Diagnoses:**

**Medications: Taken at Home? ☐ YES ☐ NO List:** ______________________
**Required at School? ☐ YES ☐ NO List:** ______________________

**IMMUNIZATIONS** – Please attach a printout of immunizations received at today's visit.

PHYSICIAN'S SIGNATURE: ______________________ DATE OF EXAM: __________

PHYSICIAN'S NAME (PRINT): ______________________ MEDICAL GROUP NAME: ______________________

ADDRESS: ______________________ PHONE: ______________ FAX: ______________