CAPP Additional Child Packet

Main Office: 131-A Stony Circle, Suite 300, Santa Rosa, CA 95401 (707) 544-3077

Dear Parent/Guardian,

Please complete the following forms for each additional child you would like to enroll.

Additional enrollment and "Need for Services" forms are available at the 4Cs main office, or online at: https://www.sonoma4cs.org/forms/.

If you have any questions, please call (707) 544-3077. Thank you!

Sincerely,

Early Care and Education Services Department
Community Child Care Council of Sonoma County (4Cs)
131-A Stony Circle, Suite 300, Santa Rosa, Ca 95401

Paquete CAPP para Niño Adicional

Estimado Padre/Madre/Guardián,

Por favor llene y entregue documentación para cada niño/a que quiere inscribir.

Formas adicionales de inscripción y de "Necesidad de Servicios" están disponibles en la oficina principal de 4Cs o en línea en: https://www.sonoma4cs.org/forms/.

Si tiene preguntas, por favor llame al (707) 544-3077. ¡Gracias!

Sinceramente,

Departamento de Servicios de Cuidado y Educación Temprana
Community Child Care Council of Sonoma County (4Cs)
131-A Stony Circle, Suite 300, Santa Rosa, Ca 95401

*****Para Español, vea los formularios del paquete al reverso.**

Our Mission is to provide access to quality child care and early education in Sonoma County through advocacy, direct service, and empowerment.

CHILD SUPPORT AND CUSTODY DECLARATION

Name(s) of child(ren): _____

☐ **If both of the child(ren)'s biological/adoptive parents live in the same household, mark this box and sign & date below.**

☐ **If one or both of the child(ren)'s biological/adoptive parent(s) do not live in your household, mark this box and complete the following:**

Name(s) of the biological/adoptive parent(s) **not** living in your household**:** _____

Child support and other forms of payments (mark appropriate statement(s) below):
***=Must attach supporting documentation**

☐ I do **not** receive any child support payments:
- ☐ I have **never** had a claim filed through the Department of Child Support Services.
- ☐ Child Support case was closed on _____.*
- ☐ A claim has been filed through the Department of Child Support Services, but I am not receiving payments.* Indicate County: _____

☐ I **receive** child support in the amount of $_____ per month:
- ☐ Directly from Department of Child Support Services*. Indicate County: _____
- ☐ Child Support Disregard through the Department of Human Services.*
- ☐ Directly from the biological/adoptive parent(s) not in the household:
  - ☐ I am able to provide supporting documentation.*
  - ☐ I am unable to provide supporting documentation from the biological/adoptive parent(s).

☐ I **receive** financial assistance in the amount of $_____ per month in the form of _____ (e.g. money towards housing costs/car payments).*

☐ I **receive** spousal support in the amount of $_____ per month.*

☐ I **pay** out $_____ per month in child and/or spousal support.*

Describe your custody arrangement (e.g. physical/legal, sole/joint) ☐ **Verbal OR** ☐ **Court Ordered**

_____

(Include days and times when child(ren) are in the custody of the biological/adoptive parent(s) not living in your household)

I declare under penalty of perjury that the above information is true and correct.

_____

Parent/Guardian's Signature Date

State Department of Education
Early Education and Support Division
CD-9607 (Rev 09/05)

To be completed by parent or guardian and updated at recertification and as changes occurs.

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/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE 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
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

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?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, 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/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

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: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

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.

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