Early Childhood Learning Center

IUSD

Preschool 3-4 year old Enrollment Packet

Health and Development Form
Parent Consent Form for QRIS
Acknowledgment of Receipt of Parent Handbook
Parent Rights, Personal Rights, & Consent for Medical Treatment
Physician's Report-Due within the first 30 days of starting school

Complete ***all*** documents either print or email them to: **ECLCEnroll@iusd.org,**
then please come to or contact the front office to continue the enrollment process.

IRVINE UNIFIED SCHOOL DISTRICT

1 Smoketree Lane Irvine, CA 92604
Office: (949) 936-5890 - FAX: (949) 936-5859
Email: ECLCEnroll@iusd.org,

Early Childhood Learning Center

Form F Where 'Little' is Great!

Health and Development Questionnaire

The information collected in this document is designed to assist us in understanding your child's specific needs and in developing an appropriate educational program. It is important that you answer all the questions as honestly and accurately as possible. If you do not know the answer to a question please put a question mark in the space.

Child's Full Name: _____ Nickname: _____

Date of Birth: _____ Sex: ☐M ☐F Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____

Child's first spoken language: _____ Language **child** uses at home: _____

Language **parent** uses to speak to child: _____ Language **adults** use at home: _____

Parent's primary language: _____ Do **parents** require an interpreter? ☐Yes ☐No

Does **child** require an interpreter? ☐Yes ☐No Is the **child** Hispanic or Latino? ☐Yes ☐No

Child's race: ☐Indigenous/Alaskan Native ☐Asian ☐Black/African American
☐Native Hawaiian/Pacific Islander ☐White

If multilingual, what percentage of time does your **child** use English? ☐10% ☐30% ☐50% ☐70% ☐90%

Family Information

1. Parent 1 Name: _____DOB:_____ Lives with child? ☐Yes ☐No

Relationship to child (e.g., biological mother/father, grandparent, adopted mother, etc.): _____

Please check one box: ☐Married ☐Divorced ☐Separated ☐Unmarried

Highest level of schooling completed? ☐High school ☐College ☐Graduate Studies

Occupation: _____ Employed? ☐Yes/Where: _____ ☐No

History of drug use, alcohol abuse or criminal conviction? ☐Yes ☐No If yes, explain: _____

_____

2. Parent 2 Name: _____DOB:_____ Lives with child? ☐Yes ☐No

Relationship to child (e.g., biological mother/father, grandparent, adopted mother, etc.): _____

Please check one box: ☐Married ☐Divorced ☐Separated ☐Unmarried

Highest level of schooling completed? ☐High school ☐College ☐Graduate Studies

Occupation: _____ Employed? ☐Yes/Where: _____ ☐No

History of drug use, alcohol abuse or criminal conviction? ☐Yes ☐No If yes, explain: _____

_____

Any past or current family, educational, social, psychological or medical issues/problems/changes? ☐Yes ☐No
If yes, explain: _____

4. Please list all brothers and sisters and any **CHILDREN** living with the family

Name	Date of Birth	Relation to child	Living with child?
			◯ Yes ◉ No
			◯ Yes ◉ No
			◯ Yes ◉ No
			◯ Yes ◯ No
			◯ Yes ◯ No

5. Other **ADULTS** living with or caring for the child; their birthdate and relationship (e.g., sibling, extended family, care-giver, etc.)

Name	Date of Birth	Relation to child	Living with child? (Yes/No)	Caring for child? (Yes/No)

6. Has the child ever lived away from their immediate family? ☐No ☐Yes If yes, explain: _____

_____

7. Any immediate or extended family members with history of developmental disabilities, delays or concerns (please specify relation to child and disability, delay or concern)? _____
_____

8. Any significant or noteworthy events or experiences in your child's or family's life (e.g., loss/change of family home, divorce, death of family member, etc.)? _____

_____

Pregnancy/Delivery Information

1. Mother's total number of pregnancies: ____ Mother's age during this pregnancy? ____ #of Living children? ___

2. Relationship with father during pregnancy: ☐Married ☐Divorced ☐Dating ☐No Relationship

3. Was there prenatal care during the pregnancy? ☐Yes ☐No If yes, what month did it begin?_____

4. Did the mother have any health problems during the pregnancy (illness, infections, etc.)? ☐Yes ☐No

If yes, explain: _____

5. Did the mother take any medication (Aspirin,antibiotics,etc.) or hormones (birth control,etc.) during pregnancy? ☐Yes ☐No If yes, explain: _____

6. Did the mother smoke, use drugs or consume alcohol at any time during the pregnancy? ☐Yes ☐No
If yes, explain: _____

7. Did the mother experience any noteworthy stress during the pregnancy (e.g., marital, job, family, financial, physical, emotional)? ☐Yes ☐No If yes, explain: _____

8. How long was the pregnancy (in weeks)? _____ Was labor: ☐Spontaneous ☐Induced

Any medication given? ☐Yes ☐No If yes, explain: _____

9. Length of labor in hours? _____ Type of delivery: ☐Breech ☐Vaginal ☐Caesarean ☐Forceps If breech, Caesarean or forceps, please briefly explain why: _____

10. Weight at birth: _____ Length at birth: _____

11. Any complications/problems during labor or delivery (cord around neck, hemorrhaging, injuries)? ☐Yes ☐No If yes, explain: _____ (include epidural, anesthesia, or meds)

12. Number of days baby was in the hospital? _____ Number of days mother was in hospital? _____

13. Did the baby or mother have any conditions, infections or problems after birth? _____

_____

Health History

1. Hearing/Vision History:

	Yes	No	If Yes, date & outcome
Has your child had a vision exam?	◯	◯	
Current vision concerns?	◯	◯	Glasses?
Has your child had a hearing exam?	◯	◯	
Current hearing concerns?	◯	◯	Hearing aids?
Has your child had a history of ear infections?	◯	◯	Frequency?
Has your child had tubes inserted in their ears?	◯	◯	Date

2. Has your child been formally diagnosed with a condition or disability described below?

Diagnosis	Yes	No	Explanation (Please include medications if applicable)	Date of Diagnosis & Diagnosing Physician
Allergies (food, environmental, etc.) Life threatening? ☐Yes ☐ No EpiPen needed at school? ☐Yes ☐No	◯	◯		
Asthma	◯	◯		
Autism	◯	◯		
ADD/ADHD	◯	◯		
Brain Injury	◯	◯		
Cancer	◯	◯		
Cerebral Palsy	◯	◯		
Genetic Disorder (Down syndrome, deletion/mutation)	◯	◯		
Gastrointestinal disorder	◯	◯		
Heart Condition Under doctor's care? ☐Yes ☐ No	◯	◯		
Neurological/Neuromuscular Condition	◯	◯		
Seizures/Epilepsy (febrile/non-febrile) Under doctor's care? ☐Yes ☐ No	◯	◯	List seizure type: Date of last episode:	
Skin Condition	◯	◯		
Other:	◯	◯		

3. Medical History: Please check mark 'Yes' or 'No' and when appropriate, provide dates/comments/explanation

	Yes	No	Dates/comments
Emergency Room Visits	◯	◯	
Serious Accident	◯	◯	
Surgery	◯	◯	
Hospitalization	◯	◯	
Activity Restrictions due to diagnosis (e.g. climbing, running)	◯	◯	
Food/Diet Restrictions	◯	◯	
Current Medications	Dosage and Frequency		Comments
History of Medications:	Dosage and Frequency		Comments

4. Date of last ***medical*** exam? _____ Date of last ***dental*** exam? _____

5. Any safety concerns/restrictions for your child playing on preschool playground equipment? ☐No ☐Yes

If yes, explain: _____

6. Please note below any other safety or health concerns you have for your child: _____

_____

7. Developmental Milestones ~ Provide the approximate age in months/years the child accomplished this:

Smiled in response to people:	Dressed Self:
Rolled over:	First single word(s):
Sat alone:	Two-word phrases:
Crawled:	Three-word phrases:
Walked Alone:	# of words per utterance:
Ate solid food:	# of words in your child's vocabulary:
Fed self with fork/spoon:	% of speech intelligible to others:
Toilet trained day:	Toilet trained night:
Sleep through the night:	Sleep through night began at:
Concerns about feeding/eating habits? If yes, explain:	

Does your child:	**Yes**	**No**
Use a pacifier	◯	◯
Suck his/her thumb	◯	◯
Sleep in parent's bed	◯	◯

8. Sensory Development, Please check 'yes' or 'no' to each question:

Auditory System: Is your child . . .	**Yes**	**No**
Bothered by any household or ordinary sounds (e.g., vacuum, dryer, toilet, etc.)?	◯	◯
Distracted by sounds not usually noticed by other people?	◯	◯
Easily distracted by irrelevant noises (e.g., lawn mower outside, air conditioner, lights, etc.)	◯	◯
Overly sensitive to sounds?	◯	◯
If any checked yes, please explain:		
Gustatory/Olfactory System: Does your child . . .	**Yes**	**No**
Have strong preferences for certain food textures?	◯	◯
Gag or vomit on certain food textures?	◯	◯
If any checked yes, please explain:		
Proprioception System: Does your child seem . . .	**Yes**	**No**
Driven to seek activities such as pushing, pulling, dragging, lifting, jumping?	◯	◯
Unsure of how far to raise/lower the body (e.g., when sitting down, stepping over)?	◯	◯
To exert too much pressure for the task (e.g., slamming doors, pressing too hard)?	◯	◯
To bump or push other children	◯	◯
Chew on toys, clothes or other objects more than other children?	◯	◯
If any checked yes, please explain:		

Tactile System: Does your child . . .	Yes	No
Pull away from being touched lightly?	◯	◯
Struggle against being held?	◯	◯
Have a tendency to touch things constantly?	◯	◯
Seem bothered by having their face washed or teeth brushed?	◯	◯
Avoid getting their hands in finger paint, glue, sand, clay or other messy things?	◯	◯
If any checked yes, please explain:		

Vestibular System: Does your child . . .	Yes	No
Demonstrate distress when they are moved or riding on moving equipment?	◯	◯
Like fast spinning carnival rides, such as merry-go-rounds?	◯	◯
Seems to not get dizzy when others usually do?	◯	◯
Rock themselves when stressed?	◯	◯
If any checked yes, please explain:		
Does your child have any unusual sensory sensitivities or fears? If any checked yes, please explain:	◯	◯

Social Development

1. Please describe where and how often your child interacts with other children (e.g., weekly at park, daily at daycare, twice per week in speech therapy, daily with siblings/friends at home)? _____

_____

2. How does your child interact/play with other children? Please check all that apply:
☐usually ignores them ☐imitates them ☐plays near/parallel to them ☐interacts with them ☐observes only

How would you describe your child's interactions and relationships with peers? Please describe: _____

_____

3. How would you describe your child's temperament/behavior (check all that apply)?
☐happy ☐difficult ☐easy ☐friendly ☐hyper ☐impulsive ☐inattentive ☐kind ☐social ☐defiant
☐in own world ☐withdrawn Other: _____

4. Does your child relate ***well*** to all family members? ☐Yes ☐No If **no**, explain: _____

_____

5. What types of discipline or consequences does the child experience in the home (e.g., verbal reprimands, time outs, removal of privileges, rewards, giving in to child, avoiding child, redirecting child, etc.)? Please specify below the common reason, method and response to discipline:

Common Reason Child is Disciplined	Method of Discipline	Child's Response to Discipline

6. Please list your child's favorite activities, foods, games, books and toys: _____

_____

_____

7. Please check either 'yes' or 'no' to each question: Does your child . . .

	Yes	No
cuddle like other children?	◯	◯
look at you when you are talking or playing?	◯	◯
smile in response to a smile from others?	◯	◯
engage in reciprocal, back-and-forth play?	◯	◯
play simple imitation games (e.g., pat-a-cake or peek-a-boo)?	◯	◯
show interest in other children?	◯	◯
point with his/her finger?	◯	◯
gesture (e.g., nod yes and no)?	◯	◯
direct your attention by holding up objects for you to see?	◯	◯
show things to people?	◯	◯
give consistent response to their name or commands?	◯	◯
use rote, repetitive or echolalic speech?	◯	◯
memorize strings of words or scripts?	◯	◯
have repetitive, stereotyped or odd motor behavior?	◯	◯
have preoccupations or a narrow range of interests?	◯	◯
attend more to parts of an object instead of the whole object (e.g., the wheels of a toy car)?	◯	◯
have limited or absent pretend play?	◯	◯
imitate other people's actions?	◯	◯
play with toys in the same exact way every time?	◯	◯
appear strongly attached to a specific unusual object(s)?	◯	◯
Has your child's development ever appeared to regress? If yes, please explain:	◯	◯

Preschool and Early Intervention Background Information

1. Has your child recently/currently attended a preschool and/or daycare? ☐Yes ☐No

Name of current preschool/daycare: _____

Teacher/Staff name(s): _____ Phone #:_____

Dates attended: _____ Days and times attended: _____

How do you feel your child is performing in preschool/daycare? ☐poor ☐average ☐above average

Please list any concerns regarding your child's functioning at preschool/daycare: _____

_____

2. Has your child attended other preschools/daycares? ☐Yes ☐No

Name of current preschool/daycare: _____

Teacher/Staff name(s): _____ Phone #:_____

Dates attended: _____ Days and times attended: _____ Reason for leaving: _____

3. Is your child currently a client of Regional Center? ☐Yes ☐No If yes, date eligible:_____
Service Coordinator's Name(s) & Phone #: _____

4. Have you participated in parenting classes? ☐Yes ☐No
If yes, list name of class and when: _____

5. Has the child received any assessments or services in the following areas? If so, please provide copies of the reports.

	Yes/No	**Date Services Began**	**Company**	**Contact Information**
Speech and Language				
Behavior (ABA)				
Occupational Therapy (OT)				
Physical Therapy (PT)				
Other:				

Parental Perceptions and Concerns

1. Do you have any concerns about your child's **communication** (speech or language) skills? ☐Yes ☐No
   If yes, explain:

2. Do you have any concerns about your child's **motor skills** (gross or fine)? ☐Yes ☐No
   If yes, explain:

3. Do you have any concerns about your child's **cognitive/reasoning or pre-academic skills**? ☐Yes ☐No
   If yes, explain:

4. Do you have any concerns about your child's **behavior**? ☐Yes ☐No
   If yes, explain:

5. Do you have any concerns about your child's **social-emotional or play skills**? ☐ Yes ☐ No
If yes, explain:

6. Please state any specific goals or skills that you would like your child to achieve in the next year (e.g., speak more clearly, expand expressive vocabulary, learn to match objects, improve fine motor skills, etc.):

7. Please describe your ideal preschool environment for your child (if you have a specific preschool you are interested in sending your child to, please note that as well):

8. Please note anything else you would like the Early Childhood Learning Center to consider when assessing your child, developing an education program for your child and/or providing special education services:

Signature of person completing this form: _____ Date: _____

Relationship to Child: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF STUDENT INFORMATION TO AND FROM PRESCHOOL AGENCIES

Completion of this document authorizes the disclosure and/or use of personally identifiable student information between your child's preschool, (Early Childhood Learning Center) and the Orange County Department of Education's QualityStart OC QRIS for program evaluation and service planning purposes.

USE AND DISCLOSURE INFORMATION RELATED TO:

Student Name:_____
Last First MI Date of Birth

I, the undersigned, do hereby authorize _____, and the Orange County Department of Education's, QualityStart OC QRIS to exchange information regarding the above named Student.

Requested information shall be limited to the following: your child's ethnicity, primary language and results from Screening Tools: ASQ-3 and ASQ-SE/Developmental Assessment: DRDP-2015/Special Needs (IFSP/IEP)

RESTRICTIONS ON RE-DISCLOSURE

California law prohibits the requestor from making further or additional disclosure of private information to another third party unless the requestor obtains another authorization from you, or the disclosure is specifically required or permitted by law.

YOUR RIGHTS

This authorization shall be for one year. However, you may revoke this authorization at any time by submitting written revocation signed by you or your representative and delivered to the agency/persons listed above. Your revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization. You have the right to receive a copy of this authorization.

Approval:_____
Printed Name Signature Date

_____
Relationship to Student Area Code and Telephone Number

Early Childhood Learning Center

Irvine Unified School District 1 Smoketree, Irvine, CA 92604

Acknowledgement of Receipt

- ❑ I acknowledge that it is my responsibility to read the ECLC Preschool Parent Handbook and abide by the policies and procedures while my family is being served at the Early Childhood Learning Center.

- ❑ I understand and acknowledge that it is my responsibility to read orientation material provided by ECLC staff.

I give my permission to use a recognizable image, still or video, of my child on a school or district website or publication, **including the school yearbook.** I give permission for my child's teacher to take pictures and send me images of my child using teacher/parent communication apps such as ClassDojo, Bloomz, Remind, or others.

❑ Allow ❑ Deny

Childs Name:_____

_____ _____

Parent/Guardian Signature Date

I will view the handbook at https://eclc.iusd.org/ _____

Initials

I have received information orienting me to the ECLC program _____

Initials

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: 75 The City Drive, Suite 250, Orange, CA 92686

   Licensing Office Telephone #: (714) 703-2882

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

LIC 995 (9/08) (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.

I.U.S.D- Early Childhood Learning Center
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

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

COMMUNITY CARE LICENSING

ADDRESS

750 THE CITY DRIVE, SUITE 250

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
ORANGE, CA	92868	(714) 703-2800

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)
I.U.S.D. - EARLY CHILDHOOD LEARNING CENTER	ONE SMOKETREE LANE, IRVINE, CA 92604

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

IUSD Early Childhood Learning Center 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
( )

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)

Early Childhood Learning Center . 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.