CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME SEX BIRTHDATE						
PARENT / AUTHORIZED REPRESEN	NTATIVE NAME	E DOES PARENT /	AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?			
PARENT / AUTHORIZED REPRESEN	NTATIVE NAME	E DOES PARENT /	AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?			
IS / HAS CHILD BEEN UNDER REGU SUPERVISION OF PHYSICIAN?	E	DATE OF LAST PH EXAMINATION	YSICAL/ MEDICAL			
DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)						
WALKED AT* MONTHS	BEGAN TALK	ING AT*	TOILET TRAINING STARTED AT*MONTHS			
PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:						
		DATES				
⑤ Chicken Pox ⑤ Asthma⑥ Rheumatic Fever⑤ Hay Fever		D	ATES			

DOES CHILD HAVE FREQUENT ON	COLDS? YES		ST YEAR? LIST ANY SHOULD BE AWARE OF
		ONFIDENTIAL) Page ces Agency Californi	e 1 of 3 a Department of Social Services
DAILY ROUTINES (*For infants a WHAT TIME DOES CHILD GET UP?*	HOURS?	<i>l-age children only)</i> DOES CHILD	BREAKFAST

DOES CHILD SLEEP DURING
THE DAY?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

DOES CHILD SLEEP WELL?*

HOW LONG?*

LUNCH

WHAT TIME DOES CHILD

BREAKFAST

LUNCH

DINNER

DOES CHILD SLEEP WELL?*

ANY FOOD DISLIKES? ANY EATING PROBLEMS?

F YES, AT
VHAT STAGE:*

NO

ARE BOWEL
MOVEMENT
REGULAR?*WHAT IS USUAL TIME?*
YES NO

WORD USED FOR "BOWEL MOVEMENT"* WORD USED FOR URINATION* PARENT

/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

	F YES, NAME	DOES CHILE	YES NO
IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? YES NO	OF DOCTOR:	TAKE PRESCRIBE MEDICATION YES NO SIDE EFFECTS:) AND ANY
DOES CHILD USE ANY SPECIAL DEVICE(S): YES NO	IF YES, WHAT KIND:	DOES CHILE ANY SPECI! DEVICE(S) AIF YES, WHAT KIND HOME?) :

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

LIC 702 (10/19) (CONFIDENTIAL) Page 2 of 3
State of California – Health and Human Services Agency California Department of Social Services

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
LIC 702 (10/19) (CONFIDENTIAL) Page 3 of 3