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

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

Montessori Autism Programs & Services
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER 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
( )	( )

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME Montessori Autism Programs & Services	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
☐ 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?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST _____
	LUNCH	LUNCH_____
	DINNER	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'S 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'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

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE
Montessori Autism Programs & Services				( )

ADDRESS NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
			( )

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
					( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	BUSINESS TELEPHONE
			( )

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE
					( )

PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE	BUSINESS TELEPHONE
			( )	( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE
			( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

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.

Reportable Communicable Diseases 2500(I)(1)

CONFIDENTIAL

Client Name:	**Date of Birth:**
Parent/Legal Guardian:	**Relationship to Client:**

Disease	Previous Condition	Current Condition
Acquired Immune Deficiency Syndrome (AIDS)		
Amebiasis		
Anaplasmosis/Ehrlichiosis		
Anthrax, human or animal		
Babesiosis		
Botulism (Infant, Foodborne, Wound, Other)		
Brucellosis, animal (except infections due to *Brucella canis*)		
Brucellosis, human		
Campylobacteriosis		
Chancroid		
Chickenpox (Varicella) (only hospitalizations and deaths)		
Clamydia trachomatis infections, including lymphogranuloma venereum (LGM)		
Cholera		
Ciguatera Fish Poisoning		
Coccidioidomyscosis		
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)		
Cryptosporidiosis		
Cyclosporiasis		
Cysticercosis or taeniasis		
Dengue		
Diptheria		
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)		
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157		
Foodborne Disease		
Giardiasis		
Gonococcal Infections		
Haemophilus influenzae, invasive disease (report an incident of less than 15 years of age)		
Hantavirus infections		
Hemolytic Uremic Syndrom		
Hepatitis A, acute infection		
Hepatitis B (specify acute case or chronic)		
Hepatitis C (specify acute case or chronic)		
Hepatitis D (Delta) (specify acute case or chronic)		
Hepatitis E, acute infection		
Influenza, deaths in laboratory-confirmed cases for age 0-64 years		
Influenza, novel strains (human)		
Legionellosis		
Leprosy (Hansen Disease)		
Leptospirosis		
Listeriosis		
Lyme Disease		
Malaria		
Measles (Rubeola)		
Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		

Disease	Previous Condition	Current Condition
Meningococcal Infections		
Mumps		
Parlytic Shellfish Poisoning		
Pelvic Inflammatory Disease (PID)		
Pertussis (Whooping Cough)		
Plague, human or animal		
Poliovirus Infection		
Psittacosis		
Rabies, human or animal		
Relapsing Fever		
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses		
Rocky Mountain Spotted Fever		
Rubella (German Measles		
Rubella Syndrome, Congenital		
Salmonellosis (Other than Typhoid Fever)		
Scombroid Fish Poisoning		
Severe Acute Respiratory Syndrome (SARS)		
Shiga toxin (detected in feces)		
Shigellosis		
Smallpox (Variola)		
Staphylococcus auereus infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of the culture)		
Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)		
Syphilis		
Tetanus		
Toxic Shock Syndrome		
Tichinosis		
Tuberculosis		
Tularemia, animal		
Typhoid Fever, Cases and Carerriers		
Vibrio Infections		
Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)		
West Nile Virus (WNV) Infection		
Yellow Fever		
Yersiniosis		
OCCURRENCE of ANY UNUSUAL DISEASE		
OUTBREAKS of ANY DISEASE (Including diseases not listed)		

Parent/Guardian Signature:

Date Form Completed:

State of California—Health and Human Services Agency

Department of Developmental Services

RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

DSP 304 (English) (Rev. 1/2000)

Reset Form Save As

Each person residing or receiving services in this facility has the following rights:

1. To wear his/her own clothes, to keep and use his/her own personal possessions including his/her toilet articles, and to keep and be allowed to spend a reasonable sum of his/her own money for canteen expenses and small purchases.
2. To have access to individual storage space for his/her private use.
3. To see visitors each day.
4. To have reasonable access to telephones, both to make and receive confidential calls.
5. To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
6. To refuse electroconvulsive therapy.
7. To refuse behavior modification techniques which cause pain or trauma.
8. To refuse psychosurgery.
9. Other rights, as specified by regulations *(see e.g., Titles 17 and 22, California Code of Regulations).*

Pursuant to Title 17, California Code of Regulations, Section 50530, the professional person in charge of the facility or his/her designee may for good cause deny a person any of the rights above under (1) through (5), inclusive.

If you believe that there was not a good reason for denying one of your rights, you may call the local clients' rights advocate who must respond to your complaint.

Name of Advocate	Address/Location of Office	Telephone ( )

It is the advocate's responsibility to investigate and resolve your complaint to your satisfaction. If the advocate is unable to do so, the complaint must be referred by the advocate to the developmental center or regional center director. After that, if the problem is still not resolved, it must be referred to the Office of Human Rights, State Department of Developmental Services.

Address/Phone # of Area Board:

Office of Human Rights
Department of Developmental Services
Sacramento, CA 95814
(916) 654-1888
TDD: (916) 654-2054

Address/Phone # of Regional Center:

This Notice must be posted, as well as distributed to each person with a developmental disability receiving services in any developmental center, licensed community care or health facility.

In addition to the above rights, persons with developmental disabilities also have the following rights:

1. A right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services or supports.
2. A right to dignity, privacy, and humane care.
3. A right to participate in an appropriate program of publicly supported education, regardless of degree of disability.
4. A right to prompt medical care and treatment.
5. A right to religious freedom and practice.
6. A right to social interaction and participation in community activities.
7. A right to physical exercise and recreational opportunities.
8. A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect.
9. A right to be free from hazardous procedures.
10. A right to make choices in their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way they spend their time including education, employment, and leisure, and pursuit of their personal future, and program planning and implementation.

Resident/Resident Representative Signature	Date

NOTE: Authority Cited: Sections 4502, 4503, and 4731, Welfare and Institutions Code