1000 VETERAN AVE., ROOM 23-10
LOS ANGELES, CA 90095-1797
MAIN OFFICE: (310) 825-4821

Dear Parents,

We would like to welcome you to the UCLA Intervention Program! Enclosed you will find a variety of forms that need to be filled out before your child can start the Program. Some of these forms need to be completed and signed by your child's physician. We ask that all of the forms be completed and returned to our office **1 week before the Meet and Greet** with your child's teacher. We realize that there is a lot of paperwork to be completed so we have attached a checklist to help you keep everything in order. You may also want to share other outside reports from physicians or therapists that can be helpful for your child's transition into the Program.

In this packet, you will find both forms required by the State of California (we are licensed by the State as a daycare facility) and others required by the Intervention Program. As part of State requirements, we ask that you bring in a copy of your child's immunization card to keep on file and that you bring a copy for our files every time the card is updated.

If you have any questions regarding the completion of this packet, please feel free to contact us. We appreciate your cooperation and are looking forward to working with you and your child.

Sincerely,

Dane Fitzmorris, M.A.
Director, UCLA Intervention Program
(310) 794-4751
dfitzmorris@mednet.ucla.edu

PARENT CHECKLIST

Forms Must Be Completed and Returned at Least One Week Prior to the Meet and Greet:

UCLA Forms

- ☐ Basic and Emergency Information
- ☐ Consent to Participate
- ☐ Attendance Policy
- ☐ Developmental History
- ☐ Privacy Protection Policy
- ☐ Photo Consent
  (For photos used within the program e.g. bulletin boards, photo albums, etc.)
- ☐ Consent to Participate In Media/Marketing Activities
  (For photos used on website, brochures, etc.)
- ☐ Community Care Licensing Waiver
- ☐ Program Roster Permission
- ☐ Authorization for Release of Health Information
- ☐ Email Consent Form
- ☐ Field Trip Permission Form

State Forms

- ☐ Identification and Emergency Information Child Care Centers
- ☐ Child's Preadmission Health History- Parent's Report
- ☐ Consent for Emergency Medical Treatment
  ** Please attach a copy of insurance card*
- ☐ Personal Rights-Child Care Centers
- ☐ Notification of Parent's Rights

Forms to give to your Child's Pediatrician to complete & sign

- ☐ Medical Clearance
- ☐ Physician's Report-Child Care Centers
  **A copy of immunization card is REQUIRED*
  (If child has not completed vaccinations, please provide required information from your child's pediatrician.)
- ☐ Authorization to Administer Medications
  - ___ Emergency Kit
  - ___ Rescue Medication
  - ___ Other
- ☐ Seizure Protocol, *REQUIRED* if applicable

Additional Items to Bring to Meet and Greet (if available):

- ☐ Copy of Child's IFSP (if child is already a client of the Regional Center)
- ☐ Outside Reports (from doctors, therapists, etc.)
- ☐ Contact Information for Child's Outside Therapists

BASIC AND EMERGENCY INFORMATION

Child's Name: _____ Child's Sex: _____ DOB: _____

Mother's Maiden Name: _____ UCLA #: _____

#1 Parent's Name: _____ #2 Parent's Name: _____

Circle one: Mother Father Circle one: Mother Father

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Regional Center/
Coordinator: _____ Referred by: _____

EMERGENCY CONTACTS

Name/Relationship	Cell Phone #	Permission to Pick Up Child?*
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

***Please only mark yes if also indicated on the State Identification and Emergency Information Child Care Centers Form)**

Doctor: _____ Phone: _____

Name of Insurance: _____ Card #: _____
(Please provide a copy of Insurance Card)

ALLERGIES:_____

CURRENT MEDICATIONS: _____

I authorize the UCLA Intervention Program to obtain emergency medical care for my child at a hospital if parent(s) or legal representative(s) or child's physician cannot be reached.

Parent's Signature: _____ Date: _____

CONSENT TO PARTICIPATE

As parents, we understand that goal of the Program is to foster our child's development. In addition, we understand that:

- the Program requires ongoing parent participation in the form of parent-and-me classroom time, meetings, phone calls, and developmental pediatrician appointments
- the Program staff includes educators, physical therapists and occupational therapists who will evaluate my child and develop and implement a plan to address my child's developmental needs
- the Program requires ongoing sharing of my child's developmental progress amongst team members in the form of both discussion and daily observational notes
- the Program provides training for professionals who desire to work with infants and young children with disabilities
- our child will have developmental evaluations at various times to help the professionals develop an effective approach to intervention and to give us information on our child's abilities, strengths and area(s) of concern
- a family's input is of the utmost importance; the team will always use our knowledge about our child to support the intervention
- we are making a commitment to the Program and will best help our child by attending regularly, this means scheduling time off around Program breaks in order to help provide consistency for our child, and the Program as well
- consistent attendance is very important for our child, but will be sure to adhere to the Program sick policy
- it is our responsibility to communicate with the team regarding any changes in our child's routine, medical history, etc. that may impact participation in the Program
- if our child is out for illness, he/she may need medical clearance to return to school and we will have our child's physician fill out the required forms
- the team of professionals will maintain our family's privacy unless consent is given to share information as outlined by Health Insurance Portability Accountability Act (HIPAA)
- the team will guide us in the process of finding the most appropriate preschool setting for our child

We have read the above description of the UCLA Intervention Program. We hereby give our consent for our child and ourselves to participate in the Program.

Parents' or Guardians' Name: _____ Signature: _____

_____ _____

Child's Name: _____ Date: _____

ATTENDANCE POLICY

The UCLA Intervention Program relies on **consistent attendance** to help children reach their fullest potential. Consistency and routine are vital parts of our program philosophy. Your commitment to bringing your child to sessions consistently and on time is critical to maintaining a positive learning relationship.

* Our teachers and therapists want to provide you with the best possible program, but can only do so if your child attends regularly.

* Absences and late arrivals may impact the continued existence of the Intervention Program because our Regional Center funding is based upon the actual time a child is in the classroom.

* When your child has unexcused absences or is consistently tardy without good reason, you are "holding" a classroom space that is not being fully utilized. (We often have a wait list.)

It is imperative that everyone work together. Consistent attendance is good for everyone!

We ask you to adhere to the following attendance policy:

- **Regular Attendance**: It is required that your child attend at least 75% of the scheduled classroom days per month. If your child's attendance falls below the required 75% (unexcused absences), you will receive an attendance warning letter. If you receive 2 warning letters in a 4 month period, you will receive a letter indicating your child is being taken off the classroom roster.
    - **Excused Absences:** We do NOT want you to bring your child when he/she is sick. Absences will be excused with a *written* Doctor's note (see Illness Policy.)
    - **Unexcused Absences**: Absences without a Doctor's note are unexcused. Please schedule appointments, vacations, etc. so as not to affect classroom attendance (see Program Calendar.)
- **Tardiness:** We understand that occasional traffic conditions and other factors can make it difficult to arrive on time. When late arrivals begin to interfere with your child's progress and/or be disruptive to the classroom, you will receive a tardiness warning letter. If you receive 2 warning letters in a 4 month period, you will receive a letter indicating your child is being taken off the classroom roster.
- **Returning to the Program:** Please know that we would like to have your child back in the program once a commitment to regular attendance is agreed upon. We want to provide you and your child with the highest quality program. (Due to limited space, date or return is subject to availability.)

I have read and understand the attendance policy and agree to follow these guidelines.

Parent/Guardian Signature	Date	Child's Name

DEVELOPMENTAL HISTORY

Dear Parents,

After your child has spent some time transitioning into the UCLA Intervention Program, he/she will receive an assessment of developmental skills. We are asking that you provide us with the information below in order to assist us in getting a complete picture of your child and his/her history in order to facilitate both the assessment and transition into the program.

As an academic program, we participate in the training of students, residents (pediatric trainees) and fellows (subspecialty trainees). Trainees may participate in several ways; by observing, participating in the classroom and reviewing records. Residents may also observe and hear classroom conversations from behind a one-way mirror. Our intervention program staff may also observe from behind the one-way mirror.

Sincerely,
Intervention Program Staff

Child's Name: _____ Date: _____

Name of the person(s) completing this form (please print): _____

Signature: _____ Relationship to the child: _____

INFORMATION ON YOUR CHILD

Child's Age: _____ Years _____ Months Child's Date of Birth: _____

Race/Ethnicity: _____ Place of Birth (State, Country, Hospital): _____

What are your current concerns about your child's development?

_____

_____

When were the concerns or problems first noticed? _____

_____

What are your child's special qualities and strengths? _____

_____

_____

Please list all your child's medical specialists (neurologist, geneticist, orthopedist, etc.):

_____

_____

_____

Please report any specialized testing (swallow study, sleep study, MRI): _____

_____

DEVELOPMENTAL HISTORY

Pregnancy, Labor and Delivery History		Yes	No	Comments
1.	Age of mother when child was born: _____ years			
2.	Is this child a twin or triplet?			
3.	In vitro fertilization involved?			
4.	Were there any problems during the pregnancy?			
5.	Any problems with other pregnancies? Miscarriages?			
6.	Amniocentesis or other fetal health tests (e.g. AFP)?			
7.	Any medications prescribed? Why?			
8.	Gestational diabetes (sugar in urine)?			
9.	Any problem with blood pressure or toxemia?			
10.	Any problems with infections (including herpes)?			
11.	Smoking during pregnancy? How many packs per day?			
12.	Drank alcohol (beer, wine, etc.) during pregnancy?			
13.	Any drugs (marijuana, cocaine, etc.) taken?			
14.	Any problems during labor or delivery?			
15.	Cesarean delivery? Why?			
14.	Is the child adopted?			If yes, what age:_____

Newborn History	Yes	No	Comments
Birth weight? _____ lbs. _____oz.			
Gestational age? _____ weeks (full term is 38-40 weeks)			
Were there any problems at birth or as a newborn?			
Were any birth defects or birth injuries noted?			
Put in Special Care or Intensive Care Nursery? _____days			
Had jaundice and needed phototherapy (bili lights)?			
Very jittery or lethargic as a newborn?			
Baby had to stay extra days in the hospital? _____days			

DEVELOPMENTAL HISTORY

(For all questions, it is OK to state "Don't recall," "Not yet," or "Not sure")

Sat at _____ months (usual age norms around 6 months)

Crawled at ____ months (norms around 9 months) Walked at __ months (norms around 12 months)

Using signs for communication? ____ (Yes/No / Past the stage)

If yes, what are the signs? (Or how many if it is difficult to list) _____

Waved bye at _____ months Babbles? _____(Yes / No / Past the stage)

Indicates what he/she wants with gestures at _____ months (norms about 12-15 months)

Using specific words? _____ (Yes/No)

If yes, what are the words? (Or how many if it is difficult to list) _____

Put two words together? _____ (Yes/No / Past the stage)

Points to pictures in a book with understanding? (e.g. responds to "Where's the dog?")_____(Yes / No)

Points to body parts? (e.g. responds to "Where's your nose?") _____ (Yes / No or how many)

Feeding skills? _____
_____ (e.g. by hand, using spoon, etc.)

Drinking skills? _____
_____ (e.g. bottle, sippy cup, regular cup, straw, etc.)

Food allergies, limited food preferences/textures? _____

Some children behave in unusual ways. Please review the following items and indicate if they describe your child's behavior.	**Not True**	**Somewhat True**	**Very True**
Makes good eye contact when talking with you			
Points to objects to show them to you			
Doesn't try to use words to communicate			
Echoes words or phrases			
Speaks in unusual tone or manner			
Hard to get child's attention			
Seems preoccupied, aloof or distant			
Repetitive behaviors (flaps hands, moves body or fingers in unusual ways)			
Prefers to be alone; ignores others			
Unusual play behaviors			
Has unusual or very intense interests			
Handles change poorly			

Describe your child's temperament: _____

_____

UCLA INTERVENTION PROGRAM

DEVELOPMENTAL HISTORY

Medical problems	Yes	No	Comments
1. Problems with vision? Crossed eyes? Wears glasses?			
2. Problems with hearing?			
3. Serious or chronic health problem (e.g. diabetes)?			
4. Birth defect or birthmarks?			
5. Hospitalizations or surgery?			
6. Serious infections or illness (e.g. meningitis)?			
7. Serious injury, burn or broken bones?			
8. Head injury or lost consciousness?			
9. Frequent accidents or multiple minor injuries?			
10. Fainting spells or dizziness?			
11. Seizures, convulsions or staring spells?			
12. Motor tics (blinking, squinting, head tossing)?			
13. Vocal tics (sniffing, grunting, throat clearing, noises)?			
14. Compulsive mannerisms (hand flapping, rocking, counting)?			
15. Serious ear infections? Chronic antibiotics or ear tubes?			
16. Serious nose, mouth or throat problems?			
17. Thyroid disorders or other hormone problems?			
18. Respiratory or lung problems (pneumonia, asthma)?			
19. Heart problems?			
20. Gastrointestinal issues (reflux, vomiting, diarrhea, constipation)?			
21. Problems with kidneys, bladder or urine?			
22. Blood problems or anemia (iron deficiency or low blood count)?			
23. Poisoning or exposure to toxic chemicals (e.g. lead)?			
24. Unusual reaction to immunization?			
25. Exposure to tobacco, alcohol or drugs?			
26. Problems with restless sleep or snoring?			
27. Difficulties with eating, diet or appetite?			
28. Difficulties swallowing? (cough, gag, gurgle)			
29. Small for age or very underweight?			
30. Over-eats or overweight?			
31. Any herbal medicines or other nutritional supplements?			
32. Any non-medical treatments (diet, chiropractic, acupuncture)?			

DEVELOPMENTAL HISTORY

Additional medical problems (if any; includes surgical procedures):

_____

Medications: _____

Allergies to medications: _____

Last hearing exam:_____ Last vision exam: _____

Family Composition

Who does the child live with? ___Birth Mother ___Birth Father ___Stepmother ___Stepfather ___Partner

___Adoptive Mother ___Adoptive Father ___Foster Mother ___Foster Father ___Guardian

___Other Adult (e.g. grandparent or boyfriend) Specify: _____

#1 Parent's name: _____ Age: _____ Occupation: _____

Highest level of school completed: _____

#2 Parent's name: _____ Age: _____ Occupation: _____

Highest level of school completed: _____

Parents' Marital Status: __Married __Never Married __Separated/Divorced __Widowed __Partner

How do the parents get along with each other? _____

If separated/divorced, how long has it been? _____

Contact with non-custodial parent or custody arrangements? _____

Does anyone else help you to baby-sit or take care of your child? (If yes, how often?)

_____

Any special circumstances in family situation? _____

What does the family enjoy doing together? _____

_____

Child's siblings or other children living <u>IN</u> the home:	**Full, half, adoptive, step, etc.**	**Age**	**Child's siblings <u>NOT</u> living in the home:**	**Full, half, adoptive, step, etc.**	**Age**

DEVELOPMENTAL HISTORY

Biological Family Medical and Psychiatric History (if adopted indicate information on any known biological relatives and indicate information on adoptive family members on lines below)

Anyone in this child's biological family have:	**Yes**	**No**	**How is this person related to child:**
Attention problems/ADHD			
Behavior problems as child or teen			
Speech or language problems			
School problems			
Reading problems or dyslexia			
Seizures or neurological problem			
Unusual drug reaction			
Mental retardation			
Birth defect or genetic disorder			
Tics/Tourette's Syndrome			
Autistic spectrum disorder			
Thyroid problems			
Heart problems before age 50			
Physical or sexual abuse			
Depression			
Bipolar/manic depression			
Social problems/shyness			
Anxiety or panic attacks			
Obsessive-compulsive disorder			
Schizophrenia			
Alcohol problems			
Drug problems			
Trouble with the law			

DEVELOPMENTAL HISTORY

Family History (Continued)

Other problems that run in biological family: _____

_____

Other problems that run in step, adoptive, or foster family: _____

_____

Any difficult circumstances in MOTHER's childhood (e.g. abuse, alcoholic parents)? _____

_____

Any difficult circumstances in FATHER's childhood (e.g. abuse, alcoholic parents)? _____

_____

Any difficult circumstances in PARENT's/PARTNER's childhood (e.g. abuse, alcoholic parents)? _____

_____

Does anyone in the family have problems similar to your child's? If so who? _____

_____

Intervention Services (If applicable):

Physical therapy
Name of therapist/clinic: _____
# of sessions per week? _____ How long? _____
Provided by (please circle): Regional Center / School District / Insurance / Self-pay
Are you satisfied with services provided? _____

Occupational therapy
Name of therapist/clinic: _____
# of sessions per week? _____ How long? _____
Provided by (please circle): Regional Center / School District / Insurance / Self-pay
Satisfied with services provided? _____

Speech therapy
Name of therapist or clinic: _____
# of sessions per week? _____How long? _____
Provided by (please circle): Regional Center / School District / Insurance / Self-pay
Satisfied with services provided? _____

Behavioral therapy
Name of therapist or clinic:_____
# of sessions per week? _____ How long? _____
Provided by (please circle): Regional Center / School District / Insurance / Self-pay
Satisfied with services provided? _____

Other services/therapies (if any): _____

PRIVACY PROTECTION POLICY

The UCLA Intervention Program has a duty to protect patient confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Use of Cell Phones, Cameras, and Other Recording Devices Is Not Allowed

Photography, Recording and Filming can <u>ONLY</u> be done by a UCLA Intervention Program staff member (when a signed consent from the parent/guardian is on file)

I have read and understand the Privacy Protection Policy and agree to follow these guidelines.

Parent/Guardian signature	Date	Child's Name

PHOTOGRAPH CONSENT

During your child's time at the UCLA Intervention Program, he/she will be participating in many fun and exciting learning activities. From time to time, we like to document these moments by photographing the children at work and play. These photographs may be posted on bulletin boards in the hallways to show other children and parents the valuable times we have in the classroom, on the play yard, out in the community, etc. We may also use these pictures to create photo albums/digital albums for the children at the time of their graduation; these albums serve as a keepsake for both the children and the families of their teachers and friends here at the program. However, as we value your families' privacy, we need your consent to photograph your children and share these pictures with other participants in the program.

☐ **Yes,** you may photograph my child for the purposes stated above.

☐ **No,** I do not want my child photographed.

_____
Child's Name

_____ _____
Parent's Signature Date

UCLA Health

MRN:
Patient Name:

(Patient Label)

CONSENT TO PARTICIPATE IN MEDIA | MARKETING ACTIVITIES
(ADULTS, MINORS AND WARDS)

PARTICIPANT TYPE:

☐ Patient ☐ Other:_____ Participant's Name:_____

Date of Birth:__/__/__ Address:_____

Phone Number: (_____)_____ E-mail (optional):_____

ACTIVITY (check all that apply)**:**

☐ Interview ☐ Photography ☐ Audio Recording ☐ Filming or Video Recording

☐ Other:_____

TYPE OF USE:

☐ By a UCLA Health representative ☐ Other: Multiple Event Use

Description:_____

UCLA Health Department:_____

FOR FUTURE PROJECTS, I AUTHORIZE THE FOLLOWING (please select one**):**

☐ UCLA may reuse the participant's image or likeness for other projects (Initial Here:_____)

☐ UCLA must request consent before reusing the participant's image or likeness for other projects (Initial Here:_____)

I understand that this authorization is voluntary. If the participant is a patient of UCLA Health, I understand that their ability to receive health care services, eligibility for benefits, or reimbursement for services is not conditioned on the signing of this authorization.

I understand that all negatives, prints, digital reproductions, recordings, and videotapes shall be the property of UCLA and shall not be returned to me or the participant.

I may cancel or revoke my authorization at any time by writing to:

UCLAHealthNews@mednet.ucla.edu

OR

UCLA Health Media Relations
924 Westwood Boulevard, Suite 350
Los Angeles, CA 90024

Revocation will be effective upon receipt, except to the extent that UCLA or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.

UCLA Health

MRN:
Patient Name:

(Patient Label)

CONSENT TO PARTICIPATE IN MEDIA | MARKETING ACTIVITIES
(ADULTS, MINORS AND WARDS)

I have read this form, and all of my questions have been answered. I hereby agree to release UCLA and those acting pursuant to their respective authority from liability for any violation of any personal or proprietary right I, or the participant, may have in connection with the use of the participant's image or likeness for the activity described above.

Signature of patient, parent or conservator _____ Date _____ Time _____

If not signed by patient, indicate relationship or guardian: _____

UCLA Representative Name _____ UCLA Representative Signature _____

Date _____ Time _____

I have accurately and completely read this consent to (patient or patient's legal representative) in the patient's or legal representative's primary language _____ (identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Signature of Translator _____ Printed Name of Translator _____

Date _____ Time _____ Translator ID # _____

COMMUNITY CARE LICENSING FORM

I,_____, the parent/guardian of _____
(Child's Name)

understand Community Care Licensing only covers toddlers aged 18-30 months. This letter is to request that my child remain in the UCLA Intervention Program until he/she is 36 months of age so the educational and therapeutic services that my child receives and needs can be continued.

_____ _____
Parent's Signature Date

PROGRAM ROSTER PERMISSION

During your time here at the Program, you will be meeting other parents and caregivers and your children will be making new friends. We have found in the past that the children, parents, and the Program truly benefit from having a friendly, supportive, and caring environment. Parents may want to socialize, share information, or coordinate play dates for their children outside of the Program. In order to facilitate these connections, we create a UCLA Intervention Program roster of currently enrolled children that is distributed to the families. The roster is completely voluntary; if you choose to be included, we will only provide the information that you provide us with at the bottom of this form.

□ **Yes**, we would like to have the following information listed on the Program Roster:

Child's Name: _____ DOB: _____

Parent(s) Name(s): _____

Address: _____

Phone #: _____ Email(s): _____

_____

□ **No**, we would prefer not to be listed on the Program Roster.

Parents' or Guardians' Name(s):	Signature(s):	Date:
_____	_____	_____
_____	_____	_____

UCLA Health

MRN:

Patient Name:
Birth Date:

AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Patient Name: _____ MRN: _____

Date of Birth: _____ SSN – Last Four Digits Only: _____

I authorize UCLA INTERVENTION PROGRAM to release PHI to:

Name of person/ facility to **receive** PHI: REGIONAL CENTER

_____

Address: _____

City, State & Zip Code: _____

Request Delivery**:** ☐ **CD** ☐ **E-Mail** ☐ **Paper Copy**

Note: If left blank, a CD will be provided.

E-Mail Address: _____

SPECIFY HEALTHCARE FACILITY FROM WHICH PHI IS REQUESTED

☒ UCLA Health Hospitals	☐ Jules Stein Eye Institute	☐ Resnick Neuropsychiatric Hospital

TYPE OF RECORDS

☒ MEDICAL	☐ MENTAL HEALTH (other than psychotherapy notes)

Information to be RELEASED

☐ Billing Statements	☐ Genetic Testing Information	☐ Pathology Reports
☒ Consultations/Evaluations	☐ HIV/AIDS Test Results	☒ Progress Notes
☐ Dental Records	☐ HIV/AIDS Treatment Information	☐ Psychological/Vocational Test Results
☐ Discharge Summary	☐ History & Physical Exams	☐ Radiology & other diagnostic Images (x-rays, etc.)
☐ Drug & Alcohol Abuse Information	☐ Laboratory Reports	☐ Radiology & other Diagnostic Reports
☐ EKG	☐ Outpatient Clinic Records	
☐ Emergency Medicine Reports	☐ Operative Reports	

☒ Other - Developmental information and telephone consultation to coordinate care.

SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE:

FROM MM / DD / YYYY TO MM / DD / YYYY

THE PURPOSE OF THIS RELEASE IS (check one or more)

☐ At the request of the patient/patient representative

☐ Other (state reason) _____

UCLA Health

MRN:
Patient Name:

AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

NOTICE

UCLA Health and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:
  1) conducting research-related treatment,
  2) obtaining information in connection with eligibility or enrollment in a health plan,
  3) determining an entity's obligation to pay a claim, or
  4) creating PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the:
  Health Information Management Services – UCLA Health
  10833 Le Conte Avenue, CHS BH-225,
  Los Angeles, CA 90095-7305.

  The revocation will take effect when UCLA Health receives it, except to the extent that UCLA Health or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date). If no date is indicated, this Authorization will expire 12 months after the date signed.

SIGNATURE

_____ Date: _____
(Signature of Patient / Legal Representative)

_____ _____
Printed Name Phone Number (Include Area Code)

(If signed by someone other than the patient, indicate relationship to the patient) _____

_____ Date: _____
Signature of Witness
(only if patient unable to sign) or Interpreter | Interpreter ID #: _____

☐ Please check box for medical records ☐ Please check box for radiology images

UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-225 Los Angeles, CA. 90095-78305 Fax: (310) 983-1468 Phone: (310) 825-6021 Email: roi@mednet.ucla.edu	**Image Management, Release of Information** 200 Medical Plaza B1- Level | Suite 165-11 Los Angeles Ca. 90095-78305 Fax 310-825-3205 Phone 310-825-6425

UCLA Health

MRN:
Patient Name:

EMAIL CONSENT FORM

- **UCLA Health Systems**
- **Santa Monica UCLA Medical Center and Orthopedic Hospital**
- **Stewart and Lynda Resnick Neuropsychiatric Hospital**

You and your Health care provider have agreed to correspond using electronic mail (E–mail). This form provides guidelines for the intended use of this type of communication, and documents for your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E–MAIL. CALL 911

E–Mail Use:	Generally, e–mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
Privacy and Confidentiality:	Unless your provider tells you specifically that the e–mail will be conducted via a secure server, consider e–mail like a postcard that can be viewed by unintended persons. In addition, the content of the e–mail may be monitored by the hospital to ensure appropriate use. Discuss with your provider who will process your e–mail messages during business hours, vacations or illness. All e–mails regarding your care will be included in your medical record.
Creating a Message:	On the "Subject" line, include the general topic of the message, for example, Prescription or Appointment or Advice. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.
Content of The Message:	E–mail should be used only for non–sensitive and non–urgent issues. Types of information appropriate for e–mail include: • Questions about prescriptions • Routine follow–up inquiries • Appointment scheduling • Reporting of self–monitoring measurements, such as blood pressure and glucose determinations. According to the California law, your provider may not communicate any lab results unless your e–mail correspondence is conducted through a secure server. Additionally, e–mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

UCLA Health

MRN:
Patient Name:

EMAIL CONSENT FORM

Response Time:	Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number below.
Ending E–Mail Relationship:	Either you or your provider may request via e–mail or letter to discontinue using e–mail as a means of communication.
Disclaimer:	**UCLA Health System, Santa Monica UCLA Medical Center and Orthopedic Hospital and Stewart and Lynda Resnick Neuropsychiatric Hospital are not responsible for e–mail messages that are lost due to technical failure during composition, transmission and/or storage.**

I have read and understand the information above, and have had any and all questions answered to my satisfaction. I agree to the guidelines for e–mail communication.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Patient E–mail address (please print): _____

Provider Name: UCLA INTERVENTION PROGRAM Telephone Number (310) 825-4821

Provider E–mail address (please print): UCLA INTERVENTION PROGRAM STAFF EMAIL ADDRESSES

FIELD TRIP PERMISSION FORM

While Attending the Program Your Child's Class Will be Going on Field Trips to:

Westwood Village / Rehab Building / Fire Station

Date: Ongoing

Time: Varied times between 9 a.m. and 12 p.m.

Transportation: Classroom wagon or stroller

Notes: Children will be supervised by classroom staff

****

Yes, I give permission for my child, _____, to participate in field trips to Westwood Village, the Rehabilitation Center Building, and/or the Fire Station while attending the UCLA Intervention Program.

In case of an emergency, I give permission for my child to receive medical treatment. In case of such an emergency, please contact:

_____ _____

(Name) ***(Phone Number)***

_____ _____

(*Parent/Guardian Signature)* ***(Date)***

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

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 ( )
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

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	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?)

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'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

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

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

UCLA Intervention Program
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
( )	( )

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:

Community Care Licensing, Southern Child Care Regional Office

NAME

El Segundo Regional Office

ADDRESS

300 N. Continental Blvd., Suite 290A, MS 29-13

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
El Segundo, CA	90245	424-301-3077

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)
UCLA Intervention Program	1000 Veteran Ave. 23-10 Los Angeles, CA 90095

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

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

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm**

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, El Segundo Regional Office

   Licensing Office Address: 300 N Continental Bl,Suite 290A,MS 29-13,El Segundo, CA 90245

   Licensing Office Telephone #: 424-301-3077

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.

UCLA Intervention Program
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

UCLA INTERVENTION PROGRAM

EMERGENCY KIT

The safety and well-being of your child is very important to us. In order to help ensure that we are prepared to care for your child if an emergency should happen during school hours, we ask that you put together an emergency kit containing the various items listed below. Please pack them in a large closable bag (except for the water) along with a 4X6 inch note card with your child's name, phone number and address. These bags will be stored in containers in a shed outside of the building as soon as your child starts the program. Since the storage space is limited, please provide only the items listed below and do not pack the items in a hard container.

Items to be included in the kit:

- ☐ Your child's medications (with authorization form attached)
    - 3-7 day supply
- ☐ 1 change of clothing, including a warm jacket/sweater
- ☐ 1 12-pack disposable diapers labeled with child's name
- ☐ 1 pack of wipes
- ☐ 1 space blanket (can be purchased at most sporting goods stores)
- ☐ 1 small comfort item (toy, blanket, doll, book, etc.)
- ☐ Small foil pouches or cans of protein food (tuna, chicken, stew, ravioli, etc.)
    - 5-7 day supply
    - Please NO NUTS or NUT BUTTER
- ☐ Favorite snacks that keep for long periods of time (fruit rolls, granola bars, crackers, etc.)
    - 5-7 day supply
    - Please NO NUTS or NUT BUTTER
- ☐ A picture of the family
- ☐ Name and phone number of an out-of-state contact person
- ☐ 2 names, phone numbers and address of relatives or friends who live or work closest to UCLA
    - You should list these people as authorized to pick-up your child on the *Identification and Emergency Information* form
- ☐ 1 package of water (6-pk. of 24-oz. bottles)
    - Please keep the bottles held together by the original plastic wrapping
    - Please keep the bottles separate from the closable bag

We must have a complete emergency kit for your child before he/she starts the program.

Thank you for helping us to create the safest environment possible for your child!