MEDICAL CLEARANCE

Dear Dr. _____ Date: _____

The parents of _____, D.O.B.: _____ would like their child to attend the UCLA Intervention Program. The program provides early intervention services provided by educational specialists, physical therapists, occupational therapists and a developmental pediatrician to infants and toddlers with a variety of developmental risks and disabilities in a group or individual setting. This child has been referred to us by their local Regional Center.

Please answer the following questions for our information:

1. This child may attend the UCLA Intervention Program. □ **Yes** □ **No**
2. This child may participate in physical therapy and occupational therapy □ **Yes** □ **No**
3. Does the child need medical equipment to participate in early intervention activities? □ **Yes** □ **No**

   If yes, please identify: _____
4. Will there be medications that need to be administered during program time? □ **Yes** □ **No**

   If yes, please specify: _____
5. Does this child have a medical condition that has required emergency attention in the past?

   □ **Yes** □ **No**

   If yes, please briefly describe: _____
6. Would this child's medical condition prevent his/her interaction with peers? □ **Yes** □ **No**

   If yes, please describe: _____
7. This child is able to participate in a parent-and-me pool play program. □ **Yes** □ **No**

_____ _____

Physician Signature Date

Physician Name and Address: _____

_____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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)

UCLA Intervention Program . This Child Care Center/School provides a program which extends from 9 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 12:00 a.m./p.m., five 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.

UCLA INTERVENTION PROGRAM

IMMUNIZATION POLICY

It is mandatory that we receive a current copy of your child's immunization record **PRIOR** to classroom attendance. The California School Immunization Law requires that your child be up-to-date on their immunizations.

Attached is the California Department of Public Health, Immunization Branch summary of immunization requirements. If your child is not up-to-date according to those requirements, classroom attendance is not possible. If your child has medical exemption or is on a medically authorized altered schedule, your child's pediatrician must provide a written statement.

UCLA INTERVENTION PROGRAM

AUTHORIZATION TO ADMINISTER MEDICATION
(FOR EMERGENCY KIT)

Child's Name: _____ Date of Birth: _____

Medication: _____ To Treat: _____

Dosage and Times to Be Administered: _____

Additional Instructions: _____

_____

Begin Date: _____ End Date: _____

Doctor's Signature: _____

Doctor's Name: _____

Doctor's Address: _____

_____

_____

Administering Medication

Medications will be administered only if:

1. The container has an unaltered label.
2. All medications and non-medication prescriptions are labeled with the child's name and date.
3. Written approval is obtained from the parent and medication is administered in accordance with label directions as prescribed by the child's physician.
4. Parents' signature indicates approval and instructions for administering medication.

I hereby give my permission to my child's teacher to administer the above-named medication to my child in the dosage indicated above. I understand that my child's teacher will inform me on a daily bases as to when such medications were administered.

_____ _____
Parent's Signature Date

*One authorization form required per medication. "Medications" include Tylenol, Benadryl, diaper rash creams, etc. Please let staff know if you need additional forms.

UCLA INTERVENTION PROGRAM

AUTHORIZATION TO ADMINISTER RESCUE MEDICATION

Child's Name: _____ Date of Birth: _____

Medication: _____ To Treat: _____

Dosage and Times to Be Administered: _____

Additional Instructions: _____

_____

Begin Date: _____ End Date: _____

Doctor's Signature: _____

Doctor's Name: _____

Doctor's Address: _____

_____

_____

Administering Medication

Medications will be administered only if:

1. The container has an unaltered label.
2. All medications and non-medication prescriptions are labeled with the child's name and date.
3. Written approval is obtained from the parent and medication is administered in accordance with label directions as prescribed by the child's physician.
4. Parents' signature indicates approval and instructions for administering medication.

I hereby give my permission to my child's teacher to administer the above-named medication to my child in the dosage indicated above. I understand that my child's teacher will inform me on a daily bases as to when such medications were administered.

_____ _____

Parent's Signature Date

*One authorization form required per medication. "Medications" include Tylenol, Benadryl, diaper rash creams, etc. Please let staff know if you need additional forms.

UCLA INTERVENTION PROGRAM

AUTHORIZATION TO ADMINISTER MEDICATION
(OTHER)

Child's Name: _____ Date of Birth: _____

Medication: _____ To Treat: _____

Dosage and Times to Be Administered: _____

Additional Instructions: _____

_____

Begin Date: _____ End Date: _____

Doctor's Signature: _____

Doctor's Name: _____

Doctor's Address: _____

_____

_____

Administering Medication

Medications will be administered only if:

1. The container has an unaltered label.
2. All medications and non-medication prescriptions are labeled with the child's name and date.
3. Written approval is obtained from the parent and medication is administered in accordance with label directions as prescribed by the child's physician.
4. Parents' signature indicates approval and instructions for administering medication.

I hereby give my permission to my child's teacher to administer the above-named medication to my child in the dosage indicated above. I understand that my child's teacher will inform me on a daily bases as to when such medications were administered.

_____ _____
Parent's Signature Date

*One authorization form required per medication. "Medications" include Tylenol, Benadryl, diaper rash creams, etc. Please let staff know if you need additional forms.

UCLA INTERVENTION PROGRAM

SEIZURE PROTOCOL

CHILD'S NAME: _____**DATE OF BIRTH:** _____

What type of seizures does the child have?_____

What do the child's seizures look like?_____

_____

_____

How long do they usually last?_____

The exact protocol that should be followed if the child is having a seizure in the classroom:_____

_____

_____

_____

NOTE: *Our general guideline is to protect and monitor the child during a seizure and call 911 if a seizure lasts 5 minutes or longer. We will also call 911 if the child is having any respiratory problems or other serious problem related to the seizure.*

What seizure medicine does the child take? What is the dosage?_____

_____

_____

NOTE: *For the earthquake kit we need a separate supply (at least 3 days - up to 2 weeks) of regular seizure medications with original prescription label, instructions for administration, and authorization to administer medication signed by the physician and the parent.*

Does the child have any seizure medication for use in emergency only? (For example, medicine used only for prolonged seizures): Yes No

If YES, please provide name of medication:_____

NOTE: *If the child requires emergency seizure medication, this must be available in the classroom along with instructions and authorization form to administer the emergency medication.*

_____ _____

Physician's Name (please print) **Physician's Telephone number**

_____ _____

Physician's Signature **Date**

_____

Parent's Signature

*IF ANY CHANGES ARE MADE TO YOUR CHILD'S MEDICATION, DOSAGE AND/OR PROTOCOL PLEASE NOTIFY US IMMEDIATELY AND A NEW FORM MUST BE COMPLETED.