

# KERN EARLY START SERVICES

- KERN REGIONAL CENTER - (661) 327-8531 • FAX (661) 327-8676
- BAKERSFIELD CITY SCHOOL DISTRICT SELPA - (661) 631-5850 • FAX (661) 631-3289
- KERN COUNTY CONSORTIUM SELPA - (661) 636-4817 • FAX (661) 636-4810
- SIERRA SANDS SELPA - (760) 499-1702 • FAX (760) 446-1639

## CHILD/FAMILY INFORMATION

- Assessment Consent signed     Parent wants copy of completed form

Date: \_\_\_\_\_

### SECTION 1: IDENTIFIED CHILD INFORMATION

**Child's Full Name:** \_\_\_\_\_  M     F  
(First, Middle, Last)

AKA: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Child's primary language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Birth Certificate # \_\_\_\_\_

SSN# \_\_\_\_\_ SELPA ID #: \_\_\_\_\_ UCI#: \_\_\_\_\_

Medi-Cal #: \_\_\_\_\_ Other ID: \_\_\_\_\_

**Present Address:** \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**School District of Residence:** \_\_\_\_\_

- Child lives with:
- Birth/adoptive parents (complete sections 2 and 4)
  - Foster parents (complete section below)
  - Legal guardians (complete section below)
  - LCI (complete section below)
  - Other: \_\_\_\_\_

#### Adult care providers (if other than parents):

Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Length of time child with above: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Message Phone: (\_\_\_\_) \_\_\_\_\_ Contact Person: \_\_\_\_\_ Language: \_\_\_\_\_

**Social Worker:** \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- (circle one)*
- Has parent search been completed?    yes    no    n/a
  - Is surrogate parent assignment necessary?    yes    no    n/a    If yes, who is surrogate? \_\_\_\_\_
  - Has parent appointed educational representative?    yes    no    n/a    If yes, who is appointee? \_\_\_\_\_

\*\*\*\*\*

Interpreter who assisted with interview: \_\_\_\_\_

Person(s) interviewed to obtain information: \_\_\_\_\_

Person(s) completing this form: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_

**CHILD/FAMILY INFORMATION (continued)**

**SECTION 2: FAMILY INFORMATION**

**MOTHER'S NAME:** \_\_\_\_\_ Maiden Name: \_\_\_\_\_ *(circle one)*  
 Highest Grade Completed: \_\_\_\_\_ birth  
 step  
 adoptive

Birthdate: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Primary Language: \_\_\_\_\_ S S #: \_\_\_\_\_

Present Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Message Phone: (\_\_\_\_) \_\_\_\_\_ Contact Person: \_\_\_\_\_ Language: \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_ *(circle one)*  
 Highest Grade Completed: \_\_\_\_\_ birth  
 step  
 adoptive

Birthdate: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Primary Language: \_\_\_\_\_ S S #: \_\_\_\_\_

Present Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Message Phone: (\_\_\_\_) \_\_\_\_\_ Contact Person: \_\_\_\_\_ Language: \_\_\_\_\_

**SECTION 3: FINANCIAL INFORMATION**

This information is not used to determine eligibility/service.

		<b>Family Income</b>
_____ SSI, Amt. _____	_____ SSA, Amt. _____	_____ under \$8,000
_____ AFDC, Amt. _____	_____ Food Stamps, Amt. _____	_____ \$8,001 - \$16,000
_____ AFDC-FC, Amt. _____	_____ WIC _____	_____ \$16,001 - \$24,000
_____ CCS, # _____	_____ Eligible condition _____	_____ \$24,001 - \$32,000
_____ Private Insurance/Company Name _____	_____	_____ \$32,001 - \$40,000
_____	_____	_____ \$40,001+
_____ Other, _____	_____	_____

**SECTION 4: AGENCY INVOLVEMENT**

Identify agencies involved with child/family:

Agency \_\_\_\_\_ Case Manager \_\_\_\_\_

Agency \_\_\_\_\_ Case Manager \_\_\_\_\_

Agency \_\_\_\_\_ Case Manager \_\_\_\_\_

Agency \_\_\_\_\_ Case Manager \_\_\_\_\_

Agency \_\_\_\_\_ Case Manager \_\_\_\_\_

**CHILD/FAMILY INFORMATION (continued)**

**SECTION 5: OTHER FAMILY MEMBER INFORMATION**

Siblings/other adults in the home:

Name	Birthdate	Age	Relationship	Remarks

**SECTION 6: HEALTH/MEDICAL HISTORY**

**A. PRENATAL AND BIRTH HISTORY**

1. Mother's age at this birth: \_\_\_\_\_
2. Number of pregnancies (including this child): \_\_\_\_\_
3. Number of live births: \_\_\_\_\_
4. Month first received prenatal care: \_\_\_\_\_  
Where?
  
5. Any illness or problems during this pregnancy?  
If so, describe.
  
6. Drug/Alcohol/Cigarettes use during this pregnancy? \_\_\_ No \_\_\_ Yes
7. Any medications taken during this pregnancy? \_\_\_ No \_\_\_ Yes  
Describe:
  
8. Duration of this pregnancy: \_\_\_\_\_
9. Name of hospital where child delivered: \_\_\_\_\_
10. Any problems during labor? \_\_\_ No \_\_\_ Yes  
If yes, describe.
  
11. Duration of labor: \_\_\_\_\_
12. Type of birth:  
\_\_\_ vaginal/head first                      \_\_\_ breech  
\_\_\_ forceps used                              \_\_\_ C-section (emergency/planned)
13. Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_
  
14. Did mother have any problems after delivery? \_\_\_ No \_\_\_ Yes  
If yes, explain.
  
15. How long was mother in the hospital? \_\_\_\_\_
16. How long was the baby in the hospital? \_\_\_\_\_ days/months  
Was the baby transferred to another hospital? \_\_\_ No \_\_\_ Yes  
If yes, name hospital and explain why baby was transferred.

**B. NEWBORN/INFANT MEDICAL HISTORY**

1. Any problems following birth? \_\_\_ No \_\_\_ Yes  
If yes, describe.

**CHILD/FAMILY INFORMATION (continued)**

2. Feeding:
- a. Is or was child breast/bottle/tube fed?
  - b. What type of formula and amount:
  - c. Is child eating baby/table foods?
  - d. Any difficulty swallowing liquids or solids? \_\_\_\_ No \_\_\_\_ Yes  
If yes, describe.

3. Developmental history
- a. At what age did the child begin to:
 

1. Roll over _____	6. Feed self _____
2. Sit alone _____	7. Run _____
3. Teethe _____	8. Be toilet trained _____
4. Crawl _____	9. Remove garments _____
5. Walk alone _____	10. Put on garments _____

Comments:

**C. SPEECH AND LANGUAGE DEVELOPMENT/STATUS**

- 1. When did the child babble? \_\_\_\_\_
- 2. When did the child speak his/her first word? \_\_\_\_\_
- 3. When did the child put several words together? \_\_\_\_\_
- 4. When did the child use sentences? \_\_\_\_\_
- 5. Does he/she understand and carry out directions when you tell him/her what to do? \_\_\_\_\_
- 6. Does he/she stutter or stammer? \_\_\_\_\_
- 7. Is his/her language development slower or faster than his siblings? \_\_\_\_\_
- 8. How does he/she communicate?
  - a. Gesturing \_\_\_\_\_
  - b. Length of sentences \_\_\_\_\_
  - c. Vocabulary \_\_\_\_\_
  - d. Imitates easily \_\_\_\_\_
  - e. Refuses to try \_\_\_\_\_
  - f. Can child be understood by:
    - 1. parents? \_\_\_\_\_
    - 2. relatives? \_\_\_\_\_
    - 3. strangers? \_\_\_\_\_
    - 4. other children? \_\_\_\_\_
  - g. Does any member of the family have speech or hearing problems? \_\_\_\_\_
  - h. Has the child ever been seen for a speech evaluation, examination, or therapy? If yes, where? \_\_\_\_\_

Medical Services/Tests	Provided by	Address	Date	Currently Following Child/Family (yes/no)
Hearing	_____	_____	_____	_____
Vision	_____	_____	_____	_____
MRI	_____	_____	_____	_____
CAT Scan	_____	_____	_____	_____
Genetic	_____	_____	_____	_____
Metabolic	_____	_____	_____	_____
Developmental/ Educational Tests	_____	_____	_____	_____
Psychological Tests	_____	_____	_____	_____
Other:	_____	_____	_____	_____

**CHILD/FAMILY INFORMATION (continued)**

**D. BIRTH FAMILY HISTORY**

1. Has anyone in the birth family had a problem similar to the child?  No  Yes  
If yes, describe. \_\_\_\_\_  
\_\_\_\_\_
2. Please circle if any relatives on either side of family have any of the following (include parents, grandparents, aunts, uncles, siblings):
- |                        |                        |
|------------------------|------------------------|
| Mental retardation     | Heart Disease          |
| Muscle Disease         | Mental Health Problems |
| Cerebral Palsy         | Emotional Problems     |
| Learning Problems      | Allergies              |
| Hyperactivity          | Thyroid Disease        |
| Diabetes, Hypoglycemia | Birth Defect           |
| Seizures/Epilepsy      | Drug/Alcohol Use       |
| Sickle Cell            | Tuberculosis           |
| Vision                 | Birth Mark             |
| Hearing                | Cancer                 |

**SECTION 7: CURRENT MEDICAL STATUS**

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ Head Circumference \_\_\_\_\_
2. Vision: Date last checked \_\_\_\_\_ Rt. Eye \_\_\_\_\_ Lt. Eye \_\_\_\_\_ Evaluated by \_\_\_\_\_
3. Hearing: Date last checked \_\_\_\_\_ Rt. Ear \_\_\_\_\_ Lt. Ear \_\_\_\_\_ Evaluated by \_\_\_\_\_
4. Dental Status: \_\_\_\_\_
5. Immunization Status: \_\_\_\_\_
6. Has the child had any serious illness/accidents/head injury/seizures/hospitalizations/operations?  No  Yes  
If yes, describe. \_\_\_\_\_
7. Diagnosis: \_\_\_\_\_  
\_\_\_\_\_
8. Current Physician(s): \_\_\_\_\_  
\_\_\_\_\_
9. Is the child currently take any medications/vitamins?  No  Yes  
If yes, complete the following.
- | Name of Medication | Dose  | Prescribing Physician | Reason |
|--------------------|-------|-----------------------|--------|
| _____              | _____ | _____                 | _____  |
| _____              | _____ | _____                 | _____  |
| _____              | _____ | _____                 | _____  |
10. Allergies: \_\_\_\_\_  
\_\_\_\_\_
11. Pending medical appointments:
- | Date  | Physician/Clinic | Reason |
|-------|------------------|--------|
| _____ | _____            | _____  |
| _____ | _____            | _____  |
| _____ | _____            | _____  |

**CHILD/FAMILY INFORMATION** (continued)

**Immunizations Dates: (mm/dd/yy)**

	#1	#2	#3	#4	#5
Polio					
DPT					
Measles					
Rubella					
Mumps					
TB (date and result)					
HIB					
Hepatitis B					

Delayed: Yes \_\_\_\_\_ No \_\_\_\_\_ Reason: \_\_\_\_\_

Waiver: Yes \_\_\_\_\_ No \_\_\_\_\_ Reason: \_\_\_\_\_

**SECTION 8: FAMILY NEEDS/CONCERNS/PRIORITIES**

1. Do you have any concerns regarding your child?

2. What type of services do you want for your child?

Comments:

