



CHILD REGISTRATION FORM



Child's Name: _____ PID #: _____

Date of Birth: Month _____ Day _____ Year _____ Age: _____ Sex: Male Female

Home Address: _____ City _____ ZIP Code: _____

Child's Race/Ethnicity: Hispanic/Latino American Indian/Alaska Native Asian African
 White Native Hawaiian/Other Pacific Islander Black/African American
 Middle Eastern Multiracial SPECIFY: _____ Other _____

Primary Language Spoken by Child: English Spanish Other _____

Does your child have any disabilities? None (N/A) Developmental Disability Hearing Impairment
 Learning Disability Physical Disability Other, SPECIFY: _____

Child's Doctor: _____ Office Group/ Location: _____
First Name Last Name

Child's Insurance: _____ Was your child premature? Yes, how many weeks? ____ No

Parent/Guardian #1 Name: _____ Marital Status: Sing. Mar. Part. Wid. Div. Sep.

Home Phone: (____) _____ Work Phone: (____) _____ Cell/Pager: (____) _____

Parent /Guardian #1 Race/Ethnicity: Hispanic/Latino American Indian/Alaska Native Asian African
 White Native Hawaiian/Other Pacific Islander Black/African American
 Middle Eastern Multiracial SPECIFY: _____ Other _____

Parent /Guardian #1 Primary Language: English Spanish Other _____

Parent /Guardian #2 Name: _____ Marital Status: Sing. Mar. Part. Wid. Div. Sep.

Home Phone: (____) _____ Work Phone: (____) _____ Cell/Pager: (____) _____

Parent /Guardian #2 Race/Ethnicity: Hispanic/Latino American Indian/Alaska Native Asian African
 White Native Hawaiian/Other Pacific Islander Black/African American
 Middle Eastern Multiracial SPECIFY: _____ Other _____

Parent/Guardian #2 Language: English Spanish Other _____

Child's Legal Guardian: Parent/Guardian #1 Parent/Guardian #2 Both Other _____

IF OTHER, Caregiver's Name: _____

IF OTHER, Caregiver's Relationship to Child:

- Relative Foster Parent
- Relative Guardian
- Other Relative, SPECIFY: _____
- Non-Relative Foster Parent
- Non-Relative Guardian
- Other Non-Relative, SPECIFY: _____

What is the best phone number to reach you?

Home Work Cell/Pager

What is the best time to reach you?

8:30am to 12pm 12pm to 3pm 3pm to 6pm
 Other: _____

Parent Authorization for Release of Information

Authorization is hereby granted for release of any information between Rady Children's Hospital and Health Center and its affiliated entities to professionals treating my child, including First 5 Commission of San Diego Health & Developmental Services Network, physicians, public health nurses, psychologists, counselors, school district personnel, CA Early Start, San Diego Regional Center, Health and Human Services Agency, California Children's Services, preschools, and child care providers. A copy of this authorization is as valid as the original.

Parent Signature _____ Date _____

For office use only: Verbal Consent Date: _____ C3 staff initials: _____

Child Name: _____

PID: _____

Date: _____ Time: _____ AM / PM By: _____

Person Calling: _____ Referral Source: _____

Referral Type: MD Self Preschool/Childcare DEC Regional Partner Other Agency

Assessment Eligibility

1. In the past 6 months, has your child been evaluated for developmental or behavioral concerns with a developmental psychologist or therapist?
 No Yes, specify _____

2. Is your child currently receiving any of the following services to help with his/her development?

<input type="checkbox"/> California Early Start, Regional Center, or HOPE	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Education services through the local school district	<input type="checkbox"/> NONE
<input type="checkbox"/> Speech and Language Therapy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Physical Therapy	

3. If so, do you feel there are other needs your child has that are not being met by these services?
 No Yes

4. Is your family experiencing any immediate problems for which you would like a referral to other services?
 Yes, specify _____ No

Action Taken

- Eligible
 - Information Only
 - Assessment at C3 Site. Appointment Date: _____
 - Treatment classes: _____
 - Other: _____
- Ineligible Reason: _____

Health Access/Utilization

1. Does your child currently have any kind of health insurance, such as Medi-Cal, Healthy Families, insurance through an HMO, a private insurance company, military benefits, or something else?
 Yes No Don't Know Decline to answer

2. Where do you take your child most when s/he is sick? (choose only one that is most representative).

<input type="checkbox"/> Primary Care Provider/ Private Physician	<input type="checkbox"/> Outside CA
<input type="checkbox"/> Community Clinic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Military Medical Facility	<input type="checkbox"/> Nowhere
<input type="checkbox"/> Urgent Care Facility	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Decline to answer

3. a. **[2 months and under]** Has your child had his/her initial medical visit?
 Yes No Don't Know Decline to answer

- b. **[2 months and up]** Has your child had any well-child checkups within this past year?
 Yes No Don't Know Decline to answer

4. **[2 months and up]** Is your child up-to-date on his/her vaccinations?
 Yes No Don't Know Decline to answer