

Clerk stamps date here when form is filed.

**To the social worker or probation officer:** If the parent or guardian needs help completing this form, please ensure that he or she receives assistance.

**To the parent or guardian:** Complete and sign this form. The information requested on this form is necessary to meet the medical, dental, mental health, and educational needs of your child. The court has directed you to provide your child's medical, dental, mental health, and educational information. The court has also directed you to provide your medical, dental, mental health, and educational information and, if you know, the same information about the other parent or guardian. If you need help, the social worker or probation officer will help you fill out this form.

Fill in court name and street address:

**Superior Court of California, County of**

Clerk fills in case number when form is filed.

**Case Number:**

① Your name: \_\_\_\_\_  
 Your relationship to child: \_\_\_\_\_  
 Your home address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Your mailing address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Your telephone: \_\_\_\_\_

② Your child's name: \_\_\_\_\_  
 a. Your child's date of birth: \_\_\_\_\_  
 b. Where was your child born? \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

c. Hospital: \_\_\_\_\_  
 d. Your child's birth weight: \_\_\_\_\_

**Child's Health**

③ Does your child have any physical or mental health challenges?  Yes  No  
 If yes, is your child receiving any assistance, services or treatment for these problems? (*Explain*):  
 a.  Allergies: \_\_\_\_\_  
 b.  Injuries: \_\_\_\_\_  
 c.  Diseases: \_\_\_\_\_  
 d.  Disabilities: \_\_\_\_\_  
 e.  Other: \_\_\_\_\_  
 f.  Other: \_\_\_\_\_

④ Is your child taking any medication?  Yes  No  
 If yes, please list the medicines and explain why your child is taking them:

Medication and dosage	Reason for taking medication	Date began
_____	_____	_____
_____	_____	_____
_____	_____	_____

⑤ When was your child last seen by a doctor?  
 Date: \_\_\_\_\_  
 Doctor's name: \_\_\_\_\_  
 Doctor's office address (*include city, state, zip code*): \_\_\_\_\_  
 Doctor's mailing address (*include city, state, zip code*): \_\_\_\_\_  
 Doctor's telephone number: \_\_\_\_\_



Child's name: \_\_\_\_\_

- 6 When was your child last seen by a dentist?  
 Date: \_\_\_\_\_  
 Dentist's name: \_\_\_\_\_  
 Dentist's office address (include city, state, zip code): \_\_\_\_\_  
 Dentist's mailing address (include city, state, zip code): \_\_\_\_\_  
 Dentist's telephone number: \_\_\_\_\_

- 7 List the names of all doctors, nurses, dentists, hospitals, clinics, and other health-care providers and healers who have seen your child within the past two years:
- | Name  | Address (city, state, zip code) | Date of last visit | Reason for visit |
|-------|---------------------------------|--------------------|------------------|
| _____ | _____                           | _____              | _____            |
| _____ | _____                           | _____              | _____            |
| _____ | _____                           | _____              | _____            |

- 8 What doctor, nurse, dentist, hospital, clinic, or other person has your child's health records?  
 a. Medical records: \_\_\_\_\_  
 b. Dental records: \_\_\_\_\_  
 c. Mental health records: \_\_\_\_\_

- 9 When was your child's eyesight last tested?  
 Date of examination: \_\_\_\_\_  
 Who examined your child's sight: \_\_\_\_\_  
 Address (include city, state, zip code): \_\_\_\_\_  
 Telephone number: \_\_\_\_\_

- 10 Does your child wear glasses?  Yes  No  
 11 Does your child wear a hearing aid?  Yes  No  
 12 Is your child covered by an insurance policy?  
 a. Medical  Yes  No (If yes, specify insurance policy): \_\_\_\_\_  
 b. Dental  Yes  No (If yes, specify insurance policy): \_\_\_\_\_  
 c. Vision  Yes  No (If yes, specify insurance policy): \_\_\_\_\_

**Child's Education**

- 13 Before your child was removed from your home, what school did your child attend?  
 Name of school: \_\_\_\_\_  
 Address (include city, state, zip code): \_\_\_\_\_  
 a. Is your child still allowed and able to attend this school?  Yes  No  
 b. If no, did you agree to give up your child's right to remain at this school?  Yes  No  
 c. Before removal, was your child receiving or had your child received any assistance or help at school or any assessments, evaluations, services, or accommodations to help your child with any physical, mental, or learning-related disabilities or other special educational needs?  Yes  No  
 (1) If yes, what assessments, evaluations, services, or accommodations was your child receiving?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (2) Who gave your child these educational services?  
 \_\_\_\_\_  
 \_\_\_\_\_



Child's name: \_\_\_\_\_

Case Number: \_\_\_\_\_

- 13 d. If applicable, do you have a copy of your child's individualized education program (IEP), section 504 plan, individual family plan (IFP), or quality of life assessment?  Yes  No
- e. What language did your child first learn to speak? \_\_\_\_\_
- f. What is his or her primary language? \_\_\_\_\_
- g. What language do you most often use when speaking to your child? \_\_\_\_\_
- h. Has your child ever been identified as English proficient or as an English language learner by a school?  
 Yes  No
- i. Has your child ever been enrolled in a specialized program to learn English?  Yes  No

- 14 List all other schools or day care your child has attended:
 

School ( <i>name, city, state</i> ): _____	Dates of attendance: _____
School ( <i>name, city, state</i> ): _____	Dates of attendance: _____
School ( <i>name, city, state</i> ): _____	Dates of attendance: _____
School ( <i>name, city, state</i> ): _____	Dates of attendance: _____

- 15 a. What grade is your child in? \_\_\_\_\_
- b. Does he or she have any special needs?  Yes  No  
If yes, please describe:  
\_\_\_\_\_
- c. If the child is three years old or younger, do you believe that the child may be eligible for services to help with motor, developmental, or other delays?  
If yes, explain why:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
What assessments, evaluations, services, treatment, or accommodations do you believe the child may need for the delay?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- d. Do you believe the child may have a disability?  
If yes, please describe:  
\_\_\_\_\_  
What assessments, evaluations, services, treatment, or accommodations do you believe the child may need for the disability?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Child's name: \_\_\_\_\_

16 Has your right to make educational decisions for the child been limited?  Yes  No

If yes, who has the right to make educational decisions for the child?

Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**Biological Parent's Health and Education** (You are required by Welfare and Institutions Code section 16010 to provide this information about yourself. If you do not want to provide this information, please talk to your attorney.)

17 a. When were you last seen by a doctor and dentist? \_\_\_\_\_

(1) What medical problems run in your family?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) Do you have medical problems or disabilities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(3) What medications do you take?

Medication

Reason for taking medications

_____	_____
_____	_____
_____	_____
_____	_____

b. What is your educational history?

(1) School last attended (name, city, state): \_\_\_\_\_

(2) Last grade completed: \_\_\_\_\_

18 a. If you know, provide the following information about your child's other parent:

(1) Name of other parent: \_\_\_\_\_

(2) Relationship to child: \_\_\_\_\_



Child's name: \_\_\_\_\_

Case Number: \_\_\_\_\_

**18** a. (3) Other parent's medical problems and disabilities

*(Please include physical, mental, and learning problems):*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(4) The child's other parent takes the following medications:

Medication	Reason for taking medications
_____	_____
_____	_____
_____	_____

(5) The following medical problems run in the family of my child's other parent:

\_\_\_\_\_  
\_\_\_\_\_

b. My child's other parent has the following educational history:

(1) School last attended: \_\_\_\_\_

(2) Last grade completed: \_\_\_\_\_

I declare under penalty of perjury under the laws of California that the information on this form is true and correct to my knowledge. This means that if I lie on this form, I am guilty of a crime.

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

\_\_\_\_\_  
*Type or print parent's/guardian's name*

▶ \_\_\_\_\_  
*Parent/guardian signs here*

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

\_\_\_\_\_  
*Type or print social worker's name*

▶ \_\_\_\_\_  
*Social worker signs here*

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

\_\_\_\_\_  
*Type or print probation officer's name*

▶ \_\_\_\_\_  
*Probation officer signs here*