CHILDREN'S LIGHTHOUSE
EARLY LEARNING SCHOOL

Physician's Recommendation for Placement in Group Care

Dear Physician,

Children's Lighthouse provides a group care setting for children between the ages of six weeks and twelve years old. It is our policy to accept children in our school in compliance with the Americans with Disabilities Act and all applicable federal, state, or local laws pertaining to the provision of services to persons with disabilities.

In addition, our school will evaluate each child's situation on an individual basis to determine if the following child's needs, including physical, can be met within our school's teacher to child ratio:

Child's Name:_____ **Date of Birth:**_____

We follow CA Title 22 regulation for group size and ratios. The Teacher to Child ratio at our school is:

Age	**INFANTS** 6wks to 18 months	**TODDLERS** 18 months to 24 months	**PRESCHOOL** **2 - 5** year olds	**SCHOOL AGE** **6 -12** year olds
Teacher : Child ratio	1 : 4	1 : 6	1 : 12	1 : 14

Admission Requirement: Please check one

1. ☐ **HEALTH-CARE PROFESSIONAL STATEMENT**: I have examined the above-named child within the past year and find that he / she **IS physically able to participate in a group care setting with the teacher to child ratio as stated above.**

OR

2. ☐ **HEALTH-CARE PROFESSIONAL STATEMENT**: I have examined the above-named child within the past year and find that he / she **is NOT physically able to participate in a group care setting with the teacher to child ratio as stated above**.

_____ _____
Health Care Professional's Signature Date

_____
Health Care Professional's Office stamp / Information

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)

Childrens Lighthouse of Riverside . This Child Care Center/School provides a program which extends from 6 : 30
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:30 a.m./p.m., 5 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.