

### CHILD'S INFORMATION SHEET

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

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

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

Name of Father: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

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

Names of Siblings  No Siblings Date of Birth

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

Religious Preference: \_\_\_\_\_

Other Languages Spoken or Understood: \_\_\_\_\_

#### Ethnicity (Check all that apply)

- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/ Other Pacific Islander
- White
- Unable to Determine

Hispanic Origin  Yes  No  Unknown

If American Indian:

Tribe: \_\_\_\_\_

\_\_\_\_\_

#### Strengths of Child

	Often	Sometime	Never		Often	Sometime	Never
Engaging personality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skill or interest in art	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive adult relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interest in academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benefits from structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skill or interest in music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skill or interest in athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responds to direction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive peer relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive manners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Good self-control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of humor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Club or group involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong academic skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**A. MEDICAL AND MENTAL HEALTH**

Name of Child's Doctor: _____		Last Exam: _____
Insurance: _____		Medicaid # _____
Allergies: _____		
Allergies to medication: _____		
Allergies to food: _____		
Medications: _____	Prescribed by: _____	
Name of Therapist or Psychiatrist: _____		Last Visit: _____
Name of Dentist: _____		Last Exam: _____
Does the child wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Eye Doctor _____		Last Exam / /
Other Doctors _____		
Medical and Psychiatric Hospitalizations _____		
Diagnosed Medical and Psychiatric Conditions _____		

PD 04-05

-2-

Detailed History of Child Abuse and Neglect or Factors that Led to the Child's Placement: \_\_\_\_\_

Identify the child's behaviors that may result in injury to self or others:

	Often	Sometime	Never		Often	Sometime	Never
Lying or Accusatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rocking or Head Banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sets Fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Holds Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bites Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assaultive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sucks Thumb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overeats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Refuses to Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruel to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parentified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Injurious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness or Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details and Comments \_\_\_\_\_

Birth of Child  Normal  Prolonged  Breech  Cesarean  
 Term of Pregnancy \_\_\_\_\_ Name of Obstetrician \_\_\_\_\_

Indicate any family history of the following:

	Mother	Father		Mother	Father
Allergies	_____	_____	Tuberculosis	_____	_____
Cancer	_____	_____	Epilepsy	_____	_____
Mental Illness	_____	_____	Kidney Disease	_____	_____
Diabetes	_____	_____	Venereal Disease	_____	_____

PD 07-26

Rheumatic Fever	_____	_____	AIDS	_____	_____
Heart Disease	_____	_____	Addiction to _____	_____	_____
Abuse or Neglect	_____	_____	Suicidal	_____	_____
Domestic Violence	_____	_____	Other	_____	_____
Details and Comments _____					

• Has the Child or Youth:  
 Received penicillin or its derivatives?  Yes  No

Been immunized for

Measles	__/__/__	Whooping Cough	__/__/__	Smallpox	__/__/__
Rubella	__/__/__	Mumps	__/__/__	Tetanus	__/__/__
Diphtheria	__/__/__	Polio	__/__/__	Other _____	__/__/__

Had the following:	Date	Physician		Date	Physician
Measles	__/__/__	_____	Pneumonia	__/__/__	_____
Mumps	__/__/__	_____	Ear Infections	__/__/__	_____
German Measles	__/__/__	_____	Bronchitis	__/__/__	_____
Scarlet Fever	__/__/__	_____	Heart Disease	__/__/__	_____
Measles	__/__/__	_____	Seizures	__/__/__	_____
Polio	__/__/__	_____	Other _____	__/__/__	_____

-3-

Seen or experienced any sexual acts?  Yes  No

• Does the child or youth know about:

Menses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abortion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Homosexuality?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**B. EDUCATION AND SOCIAL**

Name of School \_\_\_\_\_ Grade \_\_\_\_\_  
 Teachers \_\_\_\_\_

• Does the child:

Like school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have friends at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Like the teachers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stay after school often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Know how to read?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Like to be with adults?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Resist going to school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Receive special education?	<input type="checkbox"/> Yes <input type="checkbox"/> No

How much has he or she been absent? \_\_\_\_\_

What kind of student is he or she? \_\_\_\_\_

Is he or she friendly with strangers?  Yes  No

Has he or she ever been expelled or suspended?  Yes  No If yes, explain \_\_\_\_\_

In what community or special programs does the child participate? \_\_\_\_\_

**C. EATING**

At what times does the child usually eat? \_\_\_\_\_

Favorite foods \_\_\_\_\_

Foods not liked \_\_\_\_\_

Does the child:

Snack? \_\_\_\_\_ Prepare own meals or snacks? \_\_\_\_\_

Have a snack before bed? \_\_\_\_\_

**D. SLEEPING**

At what time does the child go to bed? \_\_\_\_\_

Does the child:

Comments:

- Resist being put to bed?  Yes  No \_\_\_\_\_
- Have a regular bedtime?  Yes  No \_\_\_\_\_
- Have a bedtime routine?  Yes  No \_\_\_\_\_
- Want a light on?  Yes  No \_\_\_\_\_
- Wet or soil the bed?  Yes  No \_\_\_\_\_
- Take a toy to bed?  Yes  No \_\_\_\_\_
- Sleep through the night?  Yes  No \_\_\_\_\_
- Walk or talk while sleeping?  Yes  No \_\_\_\_\_
- Have nightmares?  Yes  No \_\_\_\_\_
- Wake himself or herself?  Yes  No \_\_\_\_\_
- Take a nap?  Yes  No \_\_\_\_\_
- Use the bathroom in the night?  Yes  No \_\_\_\_\_
- Need help in the bathroom?  Yes  No \_\_\_\_\_

With whom has the child shared a room? \_\_\_\_\_

At what time does the child get up in the morning? \_\_\_\_\_

Is the child difficult to wake? \_\_\_\_\_

-4-

**E. SELF HELP**

Does the child:

- |                                    |  |                       |  |
|------------------------------------|--|-----------------------|--|
| Get dressed by himself or herself? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Brush own hair?       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Select own clothing?               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Get ready for bed?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bathe alone?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Get ready for school? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shampoo own hair?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**F. SPEECH AND HEARING**

Does the child:

- |                          |  |                            |  |
|--------------------------|--|----------------------------|--|
| Talk?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have a speech impairment?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Understand what is said? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have a hearing impairment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Follow directions?       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

What special names does the child have for objects, people, or activities? \_\_\_\_\_

**G. RECREATION AND LEISURE**

With whom does the child play? \_\_\_\_\_

What do they do together? \_\_\_\_\_

What does the child do for amusement? \_\_\_\_\_

What are the child's favorite toys? \_\_\_\_\_

Does the child:

- |                       |  |                             |  |
|-----------------------|--|-----------------------------|--|
| Play alone?           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ever play make-believe?     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Share toys?           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Like sports and group play? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Like to play outside? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swim?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Draw and color?       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ride a bicycle?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- Prefer playing with older, younger, or same-age children? \_\_\_\_\_
- Watch television?  Yes  No If yes, how often? \_\_\_\_\_

What are the child's favorite TV programs? \_\_\_\_\_

What TV shows is the child not allowed to watch? \_\_\_\_\_

Has the child been to camp or participated in groups?  Yes  No If yes, when and where? \_\_\_\_\_

Is the child afraid of any toys or activities?  Yes  No If yes, which ones? \_\_\_\_\_

**H. PERSONALITY**

Does the child:

Have any fears?  Yes  No \_\_\_\_\_

Cry often?  Yes  No

What makes the child:

Laugh? \_\_\_\_\_

Frustrated? \_\_\_\_\_

Cry? \_\_\_\_\_

Afraid? \_\_\_\_\_

How does the child:

Show affection? \_\_\_\_\_

Respond to affection? \_\_\_\_\_

How has the child been disciplined? \_\_\_\_\_

The reason for the child's placement is \_\_\_\_\_

The expected length of placement is \_\_\_\_\_

**This information will be shared with other caregivers to make a safe and appropriate placement for the child.**

Signature of CPSW or JPPO \_\_\_\_\_ Telephone \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature of Foster Parent or Residential Care Provider \_\_\_\_\_

Form completed by \_\_\_\_\_

Instructions to the "Child's Information Sheet"

**PURPOSE:**

The "Child's Information Sheet" is used to obtain essential information about a child or youth who is entering foster care, who is transferring to another foster home or residential care facility, or who is returning home. It is also used to share confidential information with caregivers to make a safe and appropriate placement for the child.

**INSTRUCTIONS:**

Form 2267 is a 5-page template initially completed by the CPSW or JPPO along with the child's parent or guardian. While the child remains in placement, the child's foster parent or residential care facility staff must update the form. The CPSW or JPPO must provide copies of the form to the parent, foster parent, and residential facility, assist with its completion, and obtain completed forms.

Form 2267 must be completed prior to the child's placement or within 30 days of placement. It must also be completed before a change in placement and prior to a child returns home. Form 2267 must be updated every 6 months while the child remains in placement.

If an ex parte order is obtained, the CPSW must enter all known information about the child and family.

The current substitute care provider retains the original Form 2267. A copy must be forwarded to the Nurse Coordinator and a copy must be retained in the case record or file. The child's subsequent care provider or parent must be provided with the latest version of Form 2267.

By signing, the substitute care provider or parent of the returning child acknowledges receipt of the form's information.

**FORM COMPLETION:**

Enter as much accurate and detailed information that identifies the child and provides essential details about his or her physical and mental health, ethnicity, school, habits, and personality. Detail specific behaviors of the child that the caregiver must be aware, such as, running away, suicide, sleepwalking.

Enter NA to indicate any information that is not available.

On page 2:

- Under Detailed History of Child Abuse and Neglect, enter the facts as described in petitions, affidavits, or other documents submitted to the court.
- Under child's behaviors and family history, add specific comments about mental health issues.

Enter information about youth for age-appropriate questions.

Sign and enter your telephone number.

Obtain the signature of the parent, foster parent, or residential care provider.

Enter the name of the person who assisted in the form's completion.

**RETENTION:**

Form 2267 must be retained permanently in the case record or file.