**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Safety and Permanence

**Intake Information Group Home Resident Under 6 Years of Age**

**Use of form:** Use of this form is voluntary. Group homes may use this form to collect the assessment information DCF 57.23(1)(a) needed to complete the treatment plan required under DCF 57.23(2) and 57.37(3) of the Wisconsin Administrative Code. Personally identifiable information gathered on this form is confidential and will be used for identification purposes only. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** Complete this form as a supplement to the DCF-F-CFS2382A-E, Intake Information – Group Home Resident. If additional space is needed when completing this form, attach separate sheets.

|  |  |  |
| --- | --- | --- |
| Name – Child      | Birthdate (mm/dd/yyyy)      | Date Form Completed (mm/dd/yyyy)      |
| **A. FEEDING, TYPES OF FOOD INTRODUCED AND MEALS** |
| Current Feeding Schedule      | Length of Time on Current Schedule      |
| New Food Timetable      |
| Food Type: |
| [ ]  Formula – specify brand.       |  | Type of formula. [ ]  Powder [ ]  Concentrate [ ]  Ready-to-feed |
| [ ]  Milk – specify type.       |
| [ ]  Strained [ ]  Junior [ ]  Table |
| When eating, the child is: [ ]  Held in lap [ ]  In highchair [ ]  Other – specify.       |
| [ ]  Yes [ ]  No Does child feed self? If “Yes”, child uses: [ ]  Hands [ ]  Spoon [ ]  Fork |
| [ ]  Yes [ ]  No Special feeding problems? If “Yes”, specify.       |
| [ ]  Yes [ ]  No Food allergies? If “Yes”, specify.       |
| Favorite foods – specify.      |
| Refused foods – specify.      |
| Special diet needs (e.g., religious, medical, etc.) – specify.      |
| **B. DIAPERING AND TOILETING PROCEDURES / SPECIAL TOILETING NEEDS** |
| Diaper type[ ]  Cloth [ ]  Disposable | Diapers provided[ ]  Yes [ ]  No | Highly sensitive skin[ ]  Yes [ ]  No | Plastic pants used[ ]  Always [ ]  Never [ ]  Sometimes – specify:       |
| Frequent diaper rash[ ]  Yes [ ]  No | [ ]  Yes [ ]  No Oil, powder or lotion used If “Yes”, specify.      |
| [ ]  Yes [ ]  No Toilet training attempted? If “Yes”, describe routine.      |
| Type of toilet seat used at home – [ ]  Potty chair [ ]  Special toilet seat [ ]  Regular toilet seat |
| [ ]  Yes [ ]  No Regular bowel movements If “Yes”, how often:       | Times of day –       |
| [ ]  Yes [ ]  No Toileting problems If “Yes”, describe.      |
| [ ]  Yes [ ]  No Constipation / Diarrhea | [ ]  Yes [ ]  No Laxatives used If “Yes”, specify type.      | [ ]  Yes [ ]  No Blood in stool | [ ]  Yes [ ]  No Yeast infections |
| **C. SLEEP AND NAP SCHEDULE** |
| Current sleep schedule      | Length of time on current schedule      |
| Falls asleep easily[ ]  Yes [ ]  No | Sleep position (under 1 year of age).[ ]  Back [ ]  Other – Note: Any position other than the back must be authorized in writing by the child’s physician. |
| [ ]  Yes [ ]  No Takes favorite toy(s) to bed? If “Yes”, list toy(s).      |
| Describe mood upon awakening.      |
| Sleep disturbance / general sleeping pattern. Check all appropriate descriptions and explain. |
| [ ]  Bed rails, restraints[ ]  Cold room[ ]  Door open[ ]  Door shut | [ ]  Lights off[ ]  Lights on[ ]  Naps[ ]  Sleeps alone | [ ]  Sleeps in pajamas[ ]  Sleeps with a lot of pillows[ ]  Sleeps with toy[ ]  Sleepwalks | [ ]  Usual hours of sleep[ ]  Wakes during night[ ]  Warm room[ ]  Other – specify.       |
| Explain.       |
| **D. COMMUNICATION METHODS AND COMFORTING TECHNIQUES** |
| Language spoken by family[ ]  English [ ]  Other – specify.       | Age child began talking      | Child speaks in[ ]  Words [ ]  Sentences | Words used to describe special needs      |
| What causes the child to feel angry or frustrated?      |
| What frightens the child and how is it shown?      |
| How does the child express feelings of happiness, enjoyment, etc.?      |
| Describe each of the following. |
| a. Child’s hobbies –       |
| b. Special interests –       |
| c. Favorite foods / favorite clothing –       |
| d. Favorite toys –       |
| e. Talents –       |
| [ ]  Yes [ ]  No Does child have a fussy time? If “Yes”, explain how fussy time is handled.      |
| Child likes to be:[ ]  Held [ ]  Sung to [ ]  Rocked [ ]  Read to [ ]  Other – specify.       |
| Special things you say or do to comfort / sooth the child.      |
| **E. DEVELOPMENTAL HISTORY** |
| Is the child able to: (Check all that apply)[ ]  Sit up alone [ ]  Pull up [ ]  Crawl [ ]  Walk holding on [ ]  Walk without support [ ]  Use assistive devices – describe.       |
| [ ]  Yes [ ]  No Is the child accustomed to playmates? Supply comments.      |
| **F. BEHAVIORAL / MEDICAL HISTORY** |
|  | **Y** | **N** | **U** | **Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked “Yes” in the appropriate Comments section.** |
| 1. |   |   |   | Heart trouble, heart murmur, rheumatic fever, chest pain, irregular heartbeat, shortness of breath |
| 2. |   |   |   | Serious head injury or loss of consciousness |
| 3. |   |   |   | Headaches, migraines, dizziness / coordination / balance problems |
| 4. |   |   |   | Seizure disorder / epilepsy |
| 5. |   |   |   | Down’s syndrome, autism, mental retardation |
| 6. |   |   |   | Cancer, leukemia, or other malignancy |
| 7. |   |   |   | Hyperactive, ADD, ADHD, needs close or constant supervision |
| 8. |   |   |   | Reflux, cleft palate, choking / swallowing problems, heartburn, ulcer |
| 9. |   |   |   | Fetal alcohol effect syndrome |
| 10. |   |   |   | Cerebral Palsy, Muscular Dystrophy |
| Comments (Items H1 – H10).      |
|  | **Y** | **N** | **U** |  |
| 11. |   |   |   | Asthma |
| 12. |   |   |   | Hepatitis B – Date of test (mm/dd/yyyy):       |
| 13. |   |   |   | Arthritis, backaches, cramps or pain in legs, polio |
| 14. |   |   |   | Bursitis, sprain or dislocation of bone or joint |
| 15. |   |   |   | Urinary / kidney problems, incontinence / encopresis |
| 16. |   |   |   | Chronic diaper rash, impetigo |
| 17. |   |   |   | Sexually transmitted disease |
| 18. |   |   |   | Nausea, vomiting, jaundice, liver disease, abdominal pain, uses antacids |
| 19. |   |   |   | Eats non-food items, anemia, blood problems, mononucleosis |
| 20. |   |   |   | Blockage of nose, discharge, post-nasal drip, nosebleeds |
| Comments (Items H11 – H20).      |
|  | **Y** | **N** | **U** |  |
| 21. |   |   |   | Wheezing; bronchitis; cough, phlegm or blood; pneumonia |
| 22. |   |   |   | Hearing problems, ringing ears, discharge / chronic infection, tubes |
| 23. |   |   |   | Thyroid problems, high or low blood pressure |
| 24. |   |   |   | Frequent therapeutic exercises done by child with foster parent’s help |
| 25. |   |   |   | Medical tests; e.g., CAT scan, EEG, EKG, MRI, chest x-ray, TB skin test |
| 26. |   |   |   | Dental problems, baby bottle tooth decay, caps / crowns, spacers |
| 27. |   |   |   | Glasses, blindness, blurred or double vision, lazy eye treatment |
| 28. |   |   |   | Other medical condition(s) – specify.       |
| 29. |   |   |   | Sexual behavior that is harmful / disruptive |
| 30. |   |   |   | Any involvement of the child as victim or perpetrator in sexual intercourse, sexual contact, prostitution (s. 944.30), sexual exploitation of a child, causing a child to view or listen to sexual activity (948.055) if the information is necessary for the care of the child or for the protection of any person living in the home. |
| Comments (Items H21 – H30).      |
|  | **Y** | **N** | **U** |  |
| 31. |   |   |   | Over or underreacts to separation from parents |
| 32. |   |   |   | Difficulty establishing attachment to caregiver |
| 33. |   |   |   | Clings excessively to parent, teacher or other |
| 34. |   |   |   | Excessively / inappropriately seeks attention |
| 35. |   |   |   | Difficult to soothe |
| 36. |   |   |   | Bedwetting |
| 37. |   |   |   | Fire setting |
| 38. |   |   |   | Assaulted or abused animals |
| 39. |   |   |   | Destructive to property |
| 40. |   |   |   | Steals |
| Comments (Items H31 – H40).      |
|  | **Y** | **N** | **U** |  |
| 41. |   |   |   | Lies habitually, story-telling |
| 42. |   |   |   | Physical / verbal aggression |
| 43. |   |   |   | Disruptions at school |
| 44. |   |   |   | Has difficulty focusing or sustaining attention |
| 45. |   |   |   | Displays social / cultural conflicts |
| 46. |   |   |   | Refuses to follow instruction / rules |
| 47. |   |   |   | Temper tantrums |
| 48. |   |   |   | Takes unusual risks with personal safety |
| 49. |   |   |   | Accident prone |
| 50. |   |   |   | Gorges, hoards food |
| Comments (Items H41 – H50).      |
|  | **Y** | **N** | **U** |  |
| 51. |   |   |   | Self-injurious (i.e., cutting, picking, hair pulling) |
| 52. |   |   |   | Lethargic, apathetic, withdrawn, unresponsive |
| 53. |   |   |   | Shows bizarre / severely disturbed behavior or thoughts |
| 54. |   |   |   | Suicidal threats or gestures |
| 55. |   |   |   | Runs away (Specify the frequency, where and with whom) |
| 56. |   |   |   | Needs structured behavior management |
| 57. |   |   |   | Unexplained crying spells, emotions inappropriate to situation |
| 58. |   |   |   | Child has fears / phobias: [ ]  Darkness [ ]  Water [ ]  Animals [ ]  Cars [ ]  Heights [ ]  Others |
| 59. |   |   |   | Psychiatric diagnosis |
| Comments (Items H51 – H59).      |
| **G. CURRENT MEDICAL NEEDS AND MEDICATION MANAGEMENT** |
| Check illnesses the child currently has and explain any treatment. Also check previous illnesses and explain any resulting complications. |
| [ ]  7-day measles[ ]  Chicken pox | [ ]  German measles[ ]  Mumps | [ ]  Rubella[ ]  Scarlet fever | [ ]  Strep throat[ ]  Whooping cough |
| Explain.       |
| [ ]  Yes [ ]  No Child has allergies. If “Yes”, check all that apply and provide details (e.g., if you checked animals, is the child allergic to all animals or only one specific type?). |
| [ ]  Animals[ ]  Dairy products | [ ]  Drugs[ ]  Food | [ ]  Insect bites[ ]  Soap | [ ]  Stings[ ]  Wool | [ ]  Other – specify.       |
| Details.       |
| [ ]  Yes [ ]  No Does the child have any special medical condition? If “Yes”, check all that apply. |
| [ ]  Asthma[ ]  Cerebral palsy / mood disorder[ ]  Diabetes | [ ]  Emotional / behavior disorder including ADD / ADHD[ ]  Epilepsy / seizure disorder[ ]  Gastrointestinal or feeding concerns including special diet and supplements | [ ]  Other condition(s) requiring special care – specify.      |
| Triggers that may cause problems.      |
| Signs or symptoms to watch for.      |
| Actions to be taken to respond to symptoms.      |
| When to call placing agency / parents regarding symptoms.      |
| When to consider that the condition requires emergency medical care or reassessment.      |
| Additional information that may be helpful to the caregiver.      |
| [ ]  Yes [ ]  No Child is currently taking medications. If “Yes”, enter information in the spaces provided below. If additional space is needed, attach separate sheet. | [ ]  Yes [ ]  No Written authorization has been provided per HFS 57.25. |
| a. | Name of Medication      | Dosage / Frequency      |
|  | Reason for Medication      | Name – Prescribing Physician      |
|  | [ ]  Yes [ ]  No Have you provided this medication to the caregiver? If “No”, explain.      |
| b. | Name of Medication      | Dosage / Frequency      |
|  | Reason for Medication      | Name – Prescribing Physician      |
|  | [ ]  Yes [ ]  No Have you provided this medication to the caregiver? If “No”, explain.      |
| c. | Name of Medication      | Dosage / Frequency      |
|  | Reason for Medication      | Name – Prescribing Physician      |
|  | [ ]  Yes [ ]  No Have you provided this medication to the caregiver? If “No”, explain.      |
| **H. SUBSTANCE ABUSE** |
|  | **Y** | **N** | **U** | **Check Yes (Y), No (N) or Unknown (U) for each category listed below. Explain all items checked “Yes” in the appropriate Comments section.** |
| 1. |   |   |   | History of drug dependency / AODA issues in family |
| 2. |   |   |   | Positive for cocaine / alcohol at birth |
| Comments:      |
| **I. FAMILY AND SIGNIFICANT RELATIONSHIPS** |
|       |
| **FORM COMPLETED BY** |
| Name      | Agency      |
| **SIGNATURE** | Relationship to Child      | Date Signed (mm/dd/yyyy)      |