PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	_____
2. Constipation	_____
3. Diarrhea	_____
4. Indigestion	_____
5. Others *(specify condition)*	
_____	_____
_____	_____

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

KARING 4 KIDS ***FOSTER FAMILY AGENCY***

Fresno Lic# 107 207 200

Hanford Lic# 167 207 187

*****Official*****

TUBERCULOSIS SCREENING

CHILD'S NAME_____DOB:_____

ADDRESS: _____PH:_____

No known contact to active tuberculosis:	YES	NO
Previous intradermal Skin test:	YES	NO
Previous reaction to internal skin test:	YES	NO
If previous reaction, was X-Ray/Medication given:	YES	NO

INTRADERMAL MANTOUX 5TU (.0001MGM) PPD SKIN TEST

Given by:_____DATE:_____

Date read:_____Negative:_____Positive:_____Induration_____mm

Read by:_____Title:_____

Further Action:

_____

_____

_____

TB Test and Immunizations need to be updated within 30 days

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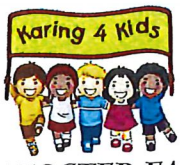
2130 N. Winery Ave Suite #101 Fresno CA 93703 Office: (559) 452-9500 Fax: (559) 452-9510



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Hanford Lic# 167 207 187

*****Official*****

VISION EXAM

CHILD'S NAME: _____ DOB: _____

DATE OF EXAMINATION: _____

RESULTS:

FOLLOW UP:

COMMENTS:

DOCTOR'S NAME: _____

DOCTOR'S SIGNATURE: _____

ADDRESS: _____

PHONE: _____

Needs to be completed within the first 30 days of placement

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DENTAL EXAM

CHILD'S NAME: _____ DOB: _____

DATE OF EXAMINATION: _____

RESULTS:

FOLLOW UP:

COMMENTS:

DOCTOR'S NAME: _____

DOCTOR'S SIGNATURE: _____

ADDRESS: _____

PHONE: _____

Needs to be completed within 30 days of placement

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KARING 4 KIDS FOSTER FAMILY AGENCY

Fresno Lic# 107 207 200

Hanford Lic# 167 207 187

Official*

CLIENT WEIGHT RECORD

RESIDENTS NAME: _____

DATE	WEIGHT	COMMENTS

Changes in weight may indicate a health problem and should be reported to the physical

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

FACILITY NAME: Karing 4 Kids FFA

FACILITY NUMBER:

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each client/resident shall be maintained for at least one year.*

NAME (LAST FIRST MIDDLE)	ADMISSION DATE	ATTENDING PHYSICIAN	ADMINISTRATOR

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY

UNIT DOSAGE RECORDED

Resident Name:

Attending Physician:

Month & Year:

Prescription Name	Hour Given	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Strength																																
Dosage																																
# of tablets																																
Prescription Name	Hour Given	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Strength																																
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Prescription Name	Hour Given	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Strength																																
Dosage																																
# of tablets																																

Staff Signature & (initial)	Staff Signature & (initial)	Staff Signature & (initial)	Abbreviations
1.	4.	7.	HV = Home Visit
2.	5.	8.	R = Refused
3.	6.	9.	

KARING 4 KIDS **FOSTER FAMILY AGENCY**

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*****Official*****

If foster child does not take any over the counter meds within the month, please fill out N/A.

Over-counter Medication					
Date:	**Time:**	**Medication:**	**Reason:**	**Dosage:**	**Initial:**

Childs Name: ____________________________

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BUMPS AND BRUISES LOG

Date:	Time:	Incident:	Treatment:	Signature:

Childs Name: _____

Please Fill out N/A when applicable and initial.

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CHILD'S MONTHLY PROGRESS REPORT

Child's Name: _____ Date of Birth: _____ Case No. _____

Foster Home: _____ For the Month of _____ Today's Date: _____

1. In the last month how did the child do in your home?
   - ☐ Doing Well -- no issues:
   - ☐ Doing Okay -- issues with: _____
   - ☐ Not Doing Okay -- because: _____
   - ☐ Were there any changes in the child's behavior? _____

2. Appraisal and Needs Service Plan DURING THE PAST MONTH — Current: _____ Next Update: _____

3. Did any accident or injury occur? ☐ Yes ☐ No *(Copy of LIC. 624 if yes)*

4. FOR CHILDREN ATTENDING KINDERGARTEN -12 GRADE
   Did the child miss any school days in the past month?
   ☐ Yes ☐ No
   What school does child attend? _____
   What grade is child in? _____
   IEP ☐ Yes ☐ No ☐ N/A

   If yes, enter the ***number of missed school days*** for each reason listed below:
   Refused to go _____ Sick _____
   Suspended _____ Expelled _____
   Other *(specify)* _____

5. In the past month did this child *(check all that apply)* ☐ Obey all laws ☐ Receive a ticket ☐ Run away ☐ Receive a citation ☐ Get arrested ☐ Police Report No. _____

PHYSICIAN, DENTAL, COUNSELING APPOINTMENTS

Date	MD, DDS, Counselor's Name	Nature of Appointment

Over the counter (OTC) or prescription medication given this month:
☐ Yes
☐ No
(Complete LIC622 if yes)

CLIENT WEIGHT/HEIGHT RECORD

Date	Height	Weight

VISITATION LOG

Date	Visited With	Location	Supervised by

CLOTHING AND ITEMS PURCHASED DURING MONTH FOR CHILD

Item Description	Amount
	$

_____ Foster Parent _____ Date _____ Social Worker _____ Date

RECORD OF CLIENT'S/RESIDENT'S SAFEGUARDED CASH RESOURCES

lient/resident: Your signature below indicates you have received the following amount of money from the facility on the date indicated.

Facilities that handle client's/resident's cash resources must maintain accurate records of all money received and disbursed.

INSTRUCTIONS:

1) *The date of the transaction shall be noted under Date.*
2) *Use a separate line for each transaction.*
3) *Supporting receipts for purchases shall be filed in order of dates of purchases.*
4) *The client's/resident's (or client's/resident's representative) signature on this form may serve as a receipt for cash distribution to the client/resident. (Sec. 80026(h)(1)(A) and 87227(g)(1)(A).*
5) *The facility representative's signature is necessary to be able to verify a cash transaction.*

NAME OF CLIENT/RESIDENT:	FACILITY NUMBER:	YEAR

DATE	DESCRIPTION	AMOUNT RECEIVED	AMOUNT SPENT OR WITHDRAWN	BALANCE	SIGNATURE FOR CASH TRANSACTIONS	
					FACILITY REPRESENTATIVE	CLIENT/RESIDENT OR REPRESENTATIVE

KARING 4 KIDS **FOSTER FAMILY AGENCY**
Fresno Lic# 107 207 200
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MONTHLY CLOTHING

CHILDS NAME: ____

DATE:	Description:	$$ Received	$$ Spent	Balance	FP Signature	FC Signature

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CLIENT/RESIDENT PERSONAL PROPERTY AND VALUABLES

Facilities must safeguard client's/resident's personal property/valuables entrusted to the facility. Licensee/Administrator is responsible for maintaining a record of personal property/valuables entrusted to and removed from the facility. Under "Number", enter the quantity of items entrusted. Under "Description", describe the item (marking articles by names or numbers may aid identification.). Under "Location", enter where items are stored. Licensee/Administrator and client/resident must sign each entry. Explain why, if client/resident does not sign. Provide a copy to the client/resident and maintain a copy in client's/resident's file. As property/valuable is removed, explain the reason for removal, enter the removal date, and ensure form is signed by all required persons specified above.

The reverse side of this form may be completed and retained in Residential Care Facilities for the Elderly to meet the notice requirements of Health and Safety Code Section 1569.153(k).

Name of Client/Resident	Social Security No.

A. PERSONAL PROPERTY/VALUABLES ENTRUSTED TO FACILITY

Number	Description	Date	Location	Signature of Client/Resident (or if "None" explain) / Signature of Licensee/Administrator

B. PERSONAL PROPERTY/VALUABLES REMOVED

Number	Description	Date	Location	Signature of Client/Resident (or if "None" explain) / Signature of Licensee/Administrator

KARING 4 KIDS ***FOSTER FAMILY AGENCY***

Fresno Lic# 107 207 200

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*****Official*****

Childs Name: _____ Date:_____

Date of Placement:

Inventory Intake

Items:	# of Items:	Date:	F/P Signature:	F/C Signature:
Jeans				
Shirts				
Shoes				
Underwear				
Socks				

Additional Information

_____

_____

_____

_____

_____

_____

_____

_____

_____

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FIRE & EVACUATION DRILL

Must complete upon placement and every 6 months

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

CLIENT(S) NAME: ____
DATE OF DRILL: ____
MEETING POINT AFTER EVACUATION: ______________________________
CLIENT INTITIAL: ______________________ FOSTER PARENT INITIAL: __________

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