

## INTAKE INFORMATION GROUP FOSTER HOME RESIDENT UNDER 6 YEARS OF AGE

**Use of form:** Use of this form is voluntary. Group foster 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 Foster 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)
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**A. FEEDING, TYPES OF FOOD INTRODUCED AND MEALS**

Current Feeding Schedule	Length of Time on Current Schedule
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New Food Timetable

Food Type:

<input type="checkbox"/> Formula – specify brand.	Type of formula. <input type="checkbox"/> Powder <input type="checkbox"/> Concentrate <input type="checkbox"/> Ready-to-feed
<input type="checkbox"/> Milk – specify type.	
<input type="checkbox"/> Strained <input type="checkbox"/> Junior <input type="checkbox"/> 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 <input type="checkbox"/> Cloth <input type="checkbox"/> Disposable	Diapers provided <input type="checkbox"/> Yes <input type="checkbox"/> No	Highly sensitive skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Plastic pants used <input type="checkbox"/> Always <input type="checkbox"/> Never <input type="checkbox"/> Sometimes – specify:
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Frequent diaper rash <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Oil, powder or lotion used If “Yes”, specify.
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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

Lights off

Sleeps in pajamas

Usual hours of sleep

Cold room

Lights on

Sleeps with a lot of pillows

Wakes during night

Door open

Naps

Sleeps with toy

Warm room

Door shut

Sleeps alone

Sleepwalks

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: <input type="checkbox"/> Darkness <input type="checkbox"/> Water <input type="checkbox"/> Animals <input type="checkbox"/> Cars <input type="checkbox"/> Heights <input type="checkbox"/> 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  German measles  Rubella  Strep throat  
 Chicken pox  Mumps  Scarlet fever  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  Drugs  Insect bites  Stings  Other – specify.  
 Dairy products  Food  Soap  Wool

Details.

Yes  No Does the child have any special medical condition? If "Yes", check all that apply.

- Asthma  Emotional / behavior disorder including ADD / ADHD  Other condition(s) requiring special care – specify.  
 Cerebral palsy / mood disorder  Epilepsy / seizure disorder  
 Diabetes  Gastrointestinal or feeding concerns including special diet and supplements

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:

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**I. FAMILY AND SIGNIFICANT RELATIONSHIPS**

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**FORM COMPLETED BY**

Name

Agency

**SIGNATURE**

Relationship to Child

Date Signed (mm/dd/yyyy)