State Department of Education
Child Development Division
CD-9607 (Rev 09/05)

To be completed by parent or guardian and updated at recertification and as changes occurs.

Emergency and Identification Information

I. Family Information

Child's name (Last, First, Middle): _____ Birth Date: _____

Mother's name: _____

Father's name: _____

Child's Address: _____ Phone: _____

Mother's business address: _____ Phone: _____

Father's business address: _____ Phone: _____

II. Names of Persons Authorized to Take Child from the Facility (This child will not be allowed to leave with any other person without written authorization from parent or guardian.)

Name	Telephone	Relationship

III. Additional Persons Who May Be Called in an Emergency to Take Child from the Facility

Name	Address	Telephone	Relationship

IV. Physician to Be Called in an Emergency

Name _____ Telephone _____

Address _____

V. Medi-Cal Number _____ Medical Insurance _____

Insurance Number _____

VI. Allergies or Other Medical Limitations _____

VII. Permission for Medical Treatment

Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.

In case of an accident or an emergency, I authorize a staff member of the child development agency to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.

Signature _____ Date _____
Parent or Guardian

Pathways

Attn: _____

FAMILY SIZE INFORMATION

Please list the names of all the **adults** that are currently residing in your household:

Names:	*Relationship to you:*	*Relationship to your children:*
1. _____	_____Self_____	_____Parent_____
2. _____	_____	_____
3. _____	_____	_____

Please list the names of all the **children** that are currently residing in your household:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I declare that I am (please mark one):

- ❑ A single-parent household.
- ❑ A two-parent household: Second Parent's Name _____

ALIMONY AND CHILD SUPPORT AFFIDAVIT

Alimony:

[ ] I am currently receiving $ _____ per month for alimony.
[ ] I am **NOT** receiving any alimony.

Child Support:

[ ] I am currently receiving $ _____ per month for child support.
[ ] I am **NOT** receiving any child support.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

Name: _____ Email Address:_____

Signature: _____ Date: _____

Pathways

3325 Wilshire Blvd Suite 1100 • Los Angeles, CA 90010
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FAMILY NEEDS ASSESSMENT – CDE SUBSIDIZED PROGRAMS

Parent Name: _____

The areas listed below are common family concerns. Check [ ] **YES** if you would like information on any of these subjects. Check [ ] **NO** if you have no needs or are not interested at this time:

Education	[ ] Yes	[ ] No	Teen Assistance	[ ] Yes	[ ] No
Health Services (Medical)	[ ] Yes	[ ] No	Legal Services	[ ] Yes	[ ] No
Family Counseling	[ ] Yes	[ ] No	Financial Assistance	[ ] Yes	[ ] No
Domestic Violence	[ ] Yes	[ ] No	Housing	[ ] Yes	[ ] No
Adult/Child Abuse	[ ] Yes	[ ] No	Special Needs	[ ] Yes	[ ] No
Emergency Assistance	[ ] Yes	[ ] No	General Information	[ ] Yes	[ ] No

What community agencies are already providing your family with support services? _____

_____

How does your family feel about the agencies and the services received? _____

_____

How do you see yourself participating in and using the Child Care Subsidy Programs? _____

_____

What kinds of things does your family like to do together? _____

_____

What are your family strengths? _____

What areas can be strengthened? _____

Is English your child's first language? [ ] Yes [ ] No, if no, what is? _____

Will you advise your child care provider of your language preference? [ ] Yes [ ] No

What do you personally want to achieve in the coming year? _____

_____

Parent signature: _____ Date: _____

****

STAFF USE ONLY:

Follow-up needed? [ ] Yes [ ] No Referrals given: Community Resources sheet

Observations: _____

Pathways Representative Initials: _____