JV-225 Your Child's Health and Education

Clerk stamps date here when form is filed.

To the social worker or probation officer: If the parent or guardian needs help completing this form, please ensure that he or she receives assistance.

To the parent or guardian: Complete and sign this form. The information requested on this form is necessary to meet the medical, dental, mental health, and educational needs of your child. The court has directed you to provide your child's medical, dental, mental health, and educational information. The court has also directed you to provide your medical, dental, mental health, and educational information and, if you know, the same information about the other parent or guardian. If you need help, the social worker or probation officer will help you fill out this form.

Fill in court name and street address:

Superior Court of California, County of

Clerk fills in case number when form is filed.

Case Number:

(1) Your name: _____
Your relationship to child: _____
Your home address: _____
City: _____ State: _____ Zip code: _____
Your mailing address: _____
City: _____ State: _____ Zip code: _____
Your telephone: _____

(2) Your child's name: _____
a. Your child's date of birth: _____
b. Where was your child born? _____
City: _____ State: _____ Country: _____
c. Hospital: _____
d. Your child's birth weight: _____

Child's Health

(3) Does your child have any physical or mental health challenges? ☐ Yes ☐ No
If yes, is your child receiving any assistance, services or treatment for these problems? *(Explain):*
a. ☐ Allergies: _____
b. ☐ Injuries: _____
c. ☐ Diseases: _____
d. ☐ Disabilities: _____
e. ☐ Other: _____
f. ☐ Other: _____

(4) Is your child taking any medication? ☐ Yes ☐ No
If yes, please list the medicines and explain why your child is taking them:

Medication and dosage	Reason for taking medication	Date began

(5) When was your child last seen by a doctor?
Date: _____
Doctor's name: _____
Doctor's office address *(include city, state, zip code):* _____
Doctor's mailing address *(include city, state, zip code):* _____
Doctor's telephone number: _____

Child's name: _____ **Case Number:**

6 When was your child last seen by a dentist?
Date: _____
Dentist's name: _____
Dentist's office address *(include city, state, zip code):* _____
Dentist's mailing address *(include city, state, zip code):* _____
Dentist's telephone number: _____

7 List the names of all doctors, nurses, dentists, hospitals, clinics, and other health-care providers and healers who have seen your child within the past two years:

Name	Address *(city, state, zip code)*	Date of last visit	Reason for visit

8 What doctor, nurse, dentist, hospital, clinic, or other person has your child's health records?
a. Medical records: _____
b. Dental records: _____
c. Mental health records: _____

9 When was your child's eyesight last tested?
Date of examination: _____
Who examined your child's sight: _____
Address *(include city, state, zip code):* _____
Telephone number: _____

10 Does your child wear glasses? ☐ Yes ☐ No

11 Does your child wear a hearing aid? ☐ Yes ☐ No

12 Is your child covered by an insurance policy?
a. Medical ☐ Yes ☐ No *(If yes, specify insurance policy):* _____
b. Dental ☐ Yes ☐ No *(If yes, specify insurance policy):* _____
c. Vision ☐ Yes ☐ No *(If yes, specify insurance policy):* _____

Child's Education

13 Before your child was removed from your home, what school did your child attend?
Name of school: _____
Address *(include city, state, zip code):* _____
a. Is your child still allowed and able to attend this school? ☐ Yes ☐ No
b. If no, did you agree to give up your child's right to remain at this school? ☐ Yes ☐ No
c. Before removal, was your child receiving or had your child received any assistance or help at school or any assessments, evaluations, services, or accommodations to help your child with any physical, mental, or learning-related disabilities or other special educational needs? ☐ Yes ☐ No
(1) If yes, what assessments, evaluations, services, or accommodations was your child receiving?
_____
_____
(2) Who gave your child these educational services?
_____
_____

Child's name: _____ **Case Number:**

13 d. If applicable, do you have a copy of your child's individualized education program (IEP), section 504 plan, individual family plan (IFP), or quality of life assessment? ☐ Yes ☐ No

e. What language did your child first learn to speak? _____

f. What is his or her primary language? _____

g. What language do you most often use when speaking to your child? _____

h. Has your child ever been identified as English proficient or as an English language learner by a school?
☐ Yes ☐ No

i. Has your child ever been enrolled in a specialized program to learn English? ☐ Yes ☐ No

14 List all other schools or day care your child has attended:

School *(name, city, state):* _____ Dates of attendance: _____
School *(name, city, state):* _____ Dates of attendance: _____
School *(name, city, state):* _____ Dates of attendance: _____
School *(name, city, state):* _____ Dates of attendance: _____

15 a. What grade is your child in? _____

b. Does he or she have any special needs? ☐ Yes ☐ No
If yes, please describe:

c. If the child is three years old or younger, do you believe that the child may be eligible for services to help with motor, developmental, or other delays?
If yes, explain why:

What assessments, evaluations, services, treatment, or accommodations do you believe the child may need for the delay?

d. Do you believe the child may have a disability?
If yes, please describe:

What assessments, evaluations, services, treatment, or accommodations do you believe the child may need for the disability?

Child's name: _____

Case Number:

16 Has your right to make educational decisions for the child been limited? ☐ Yes ☐ No
If yes, who has the right to make educational decisions for the child?
Name: _____
Relationship to child: _____

Biological Parent's Health and Education

(You are required by Welfare and Institutions Code section 16010 to provide this information about yourself. If you do not want to provide this information, please talk to your attorney.)

17 a. When were you last seen by a doctor and dentist? _____

(1) What medical problems run in your family?

_____
_____
_____
_____
_____
_____

(2) Do you have medical problems or disabilities?

_____
_____
_____
_____

(3) What medications do you take?

Medication	Reason for taking medications
_____	_____
_____	_____
_____	_____
_____	_____

b. What is your educational history?

(1) School last attended *(name, city, state):* _____
(2) Last grade completed: _____

18 a. If you know, provide the following information about your child's other parent:

(1) Name of other parent: _____
(2) Relationship to child: _____

Child's name: _____ **Case Number:**

18 a. (3) Other parent's medical problems and disabilities
(Please include physical, mental, and learning problems):

_____
_____
_____

(4) The child's other parent takes the following medications:

Medication	Reason for taking medications
_____	_____
_____	_____
_____	_____

(5) The following medical problems run in the family of my child's other parent:

_____
_____

b. My child's other parent has the following educational history:
(1) School last attended: _____
(2) Last grade completed: _____

I declare under penalty of perjury under the laws of California that the information on this form is true and correct to my knowledge. This means that if I lie on this form, I am guilty of a crime.

Date: _____

_____ ▶ _____
Type or print parent's/guardian's name *Parent/guardian signs here*

Date: _____

_____ ▶ _____
Type or print social worker's name *Social worker signs here*

Date: _____

_____ ▶ _____
Type or print probation officer's name *Probation officer signs here*