

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 help him or her.

**To the parent or guardian:** Complete and sign this form. If you need more space to answer, attach one or more sheets of paper to this form and write "JV-225" at the top of each page. The information requested on this form is necessary to meet the medical, dental, mental health, educational, and developmental needs of your child. The court has directed you to provide your child's medical, dental, mental health, educational, and developmental 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 number: \_\_\_\_\_

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 Has your child ever been admitted to the hospital for care or treatment of any of the conditions in item ③?  
 Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

⑤ Is your child taking any medication?  Yes  No  
If yes, please list each medication and explain why your child is taking it:

Medication and dosage	Reason for taking medication	Date begun
_____	_____	_____
_____	_____	_____
_____	_____	_____



Child's name: \_\_\_\_\_

6 When was your child last seen by a doctor?  
 Date: \_\_\_\_\_  
 Doctor's name: \_\_\_\_\_  
 Office address: \_\_\_\_\_  
 Mailing address (if different): \_\_\_\_\_  
 Telephone number: \_\_\_\_\_

7 When was your child last seen by a dentist?  
 Date: \_\_\_\_\_  
 Dentist's name: \_\_\_\_\_  
 Office address: \_\_\_\_\_  
 Mailing address (if different): \_\_\_\_\_  
 Telephone number: \_\_\_\_\_

8 List the names of all doctors, nurses, dentists, hospitals, clinics, and other health-care providers and healers, other than those listed in 6 and 7, who have seen your child within the past two years:

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

9 What doctor, nurse, dentist, hospital, clinic, or other health-care provider has health records regarding your child?  
 a. Medical records: \_\_\_\_\_  
 b. Dental records: \_\_\_\_\_  
 c. Mental health records: \_\_\_\_\_  
 d. Other: \_\_\_\_\_

10 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: \_\_\_\_\_

11 Does your child wear glasses or contact lenses?  Yes  No

12 Does your child wear a hearing aid?  Yes  No

13 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**

14 When your child was living with you, 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



Child's name: \_\_\_\_\_

14 c. When your child was living with you, 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 or developmental services?

\_\_\_\_\_

d. Has your child ever been referred to a regional center for developmental services?  Yes  No

If yes, list the name and location of the regional center and the date of the referral.

e. If applicable, do you have a copy of your child's individualized education program (IEP), section 504 plan, individualized family service plan (IFSP), individual program plan (IPP), or quality assurance assessment?

Yes  No

f. What language did your child first learn to speak? \_\_\_\_\_

g. What is his or her primary language? \_\_\_\_\_

h. What language do you most often use when speaking to your child? \_\_\_\_\_

i. Has your child ever been identified as limited English proficient or as an English Language Learner by a school?

Yes  No

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

15 List all other schools or day care facilities 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: \_\_\_\_\_

16 a. What grade is your child in? \_\_\_\_\_

b. Does he or she have any special needs?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. If your child is three years old or younger, do you believe that your child might have motor, developmental, or other delays?  Yes  No

If yes, explain why: \_\_\_\_\_

\_\_\_\_\_

What assessments, evaluations, services, treatment, or accommodations do you believe your child needs for the delay? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Child's name: \_\_\_\_\_

- 16 d. Do you believe your child might have a disability?  Yes  No  
If yes, please describe: \_\_\_\_\_

What assessments, evaluations, services, treatment, or accommodations do you believe your child needs for the disability? \_\_\_\_\_

- 17 a. Has your right to make educational decisions for your child been limited?  Yes  No  
If yes, who has the right to make educational decisions for your child?

Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

- b. Has your right to make developmental-services decisions for your child been limited?  Yes  No  
If yes, who has the right to make developmental-services decisions for your child?  same as 17a.

Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**Biological Parent's Health and Education** (State law requires you to provide this information about yourself. If you do not want to provide this information, please talk to your attorney.)

- 18 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?  Yes  No  
If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- (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: \_\_\_\_\_

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

(1) Name of other parent: \_\_\_\_\_



Case Number: \_\_\_\_\_

Child's name: \_\_\_\_\_

19 a. (2) Other parent's medical problems and disabilities  
(Please include physical, mental, developmental, and learning problems):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(3) My child's other parent takes the following medications:

Medication	Reason for taking medication
_____	_____
_____	_____
_____	_____

(4) 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 that the information on this form is true and correct to the best of my knowledge.

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*