San Joaquin County Public Health Services
health grows here

Child Passenger Safety Program Referral Form

Phone: (209) 468-8914

SAFE KIDS SAN JOAQUIN COUNTY

Referral Agency Information

Date: _____/_____/_____
Agency: _____
Referred by: _____
Email: _____
Phone: _____ Alt: _____
Referral follow up requested: Yes ☐ No ☐
Client is aware of referral: Yes ☐ No ☐
Does the client have a vehicle? Yes ☐ No ☐
Is this an emergency? Yes ☐ No ☐
(child being discharged from hospital, needs to travel immediately, etc.)

Primary Caregiver Information

Name: _____
Address: _____
City: _____ Zip Code: _____
Email: _____
Phone: _____ Alt: _____
Language Preference: _____
Pregnant: Yes ☐ No ☐
Expected Due Date: _____/_____/_____

Please Provide Detailed Information Below

Number of Child(ren): _____

Name, Age, Weight, and Height of Child(ren):

Child's Name:	**Child's Name:**	**Child's Name:**	**Child's Name:**
Age:	**Age:**	**Age:**	**Age:**
Height:	**Height:**	**Height:**	**Height:**
Weight:	**Weight:**	**Weight:**	**Weight:**

Special Needs/Disabilities? Yes ☐ No ☐

If so, please select all that apply:

☐ Autism ☐ Hearing Loss ☐ Cerebral Palsy ☐ Cognitive Impairment
☐ Vision Impairment ☐ ADHD ☐ Dyslexia ☐ Developmental
☐ Others: _____

Reason for needing no-cost car seat(s):

Additional Comments:

For Internal Use

Date of Referral Received: _____/_____/_____ Schedule Appointment: _____
Car Seats Distributed? Yes ☐ No ☐ Date of Case Closed: _____/_____/_____