

## **CHILD PROFILE**

Registration Date_		Start Date			
CHILD/FAMILY INFO	RMATION:				
Name of child:		Male	Female		
Date of Birth	Medicare #	E	xpiry Date		
Name of Family Physicia	ın	Telephone_	Telephone		
Address					
ALLERGY ALERT: Plea	se list your child's allergies				
Home Address		Ant # City			
	Phone # Cell#				
	Fa				
Place of Work (Mother)		Work Phone #			
Place of Work (Father)		Work Phone #			
Marital Status: Single	Married Widowed	Separated Divorced	i		
Vith whom has the child li	ived for most of the past year?	Mother Father	Both		
Guardian Other (speci	fy)				
Who has permission to pic	k your child up from the cente	r?			
	ements parents must inform t	·			
s there anyone who does	not have permission to pick yo	our child up from the center	ı f		

ENAEDCENCY CONTAC	TS (Not inclu	ding parant	s/guardians)			
EMERGENCY CONTAC	. <u>13 (</u> 110t Inclu	uing parents	s/guaruians)			
1. Name		Addr	ess			
Telephone #		Relat	ionship			
2. Name		Addr	ess			
Telephone #		Rela	Relationship			
PRESCHOOL/CHILD CA	ARE HISTORY					
Has your child attended p	reschool/child (	care hefore? `	Yes No			
If yes, for how long? 6 mg	ontus 1	year 2	years more tr	ian 2 years	<del></del>	
CHILD HEALTH RECOR	<u>∤D</u>					
Immunizations: In accord	ance with regu	lation 12(2) of	f the Public Health Δct	nroof of imm	uunization must he	
provided for each child at	_			proof of mini	dilization mast be	
•						
diptheria	rubella		mumps	mumps		
tetanus	varicella		measles	measles		
polio	meningoco	ccal disease	Haemophilus influe	Haemophilus influenza type B		
pertussis	pneumocod	cal disease	·			
•	·					
Where proof is not provide	ded you must h	ave the follow	ving waivers:			
- a medical evention	on a form prov	idad hy tha M	inister, that is signed b	y a medical ni	ractitioner or nurse	
•	on a form prov	ided by the ivi	illister, that is signed b	y a medicai pi	actitioner of fluise	
practitioner, or						
- a written statement,	on a form provi	ided by the M	inister, signed by the p	arent or lega	I guardian of his or	
her objections to the i	immunizations i	required by the	a Ministar	_	_	
ner objections to the i	illillatiizations i	required by the	e Minister.			
Note: Public Health will p	periodically revi	iew child files	to ensure immunization	ons are comp	lete or waivers are	
present						
Medical History:			Health Status:			
Please indicate if your chi	ld has <b>had</b> any o	of the followin	g: Indicate if your chil	d <b>has</b> any of t	he following:	
Medical History	Yes	No	Health Status	Yes	No	
Measles			Asthma			
Rubella			Diabetes			
Mumps			Eczema/Psoriasis			
Chicken Pox			Epilepsy/Seizures			
Meningitis			Other			
Pertussis (Whooping						

Medical Treatment: Please indicate medical treatment your child may require.

Name of Medication	Dosage
Instructions:	
<b>Emergency Treatment:</b> Please indicate a be required by your child (i.e.: Epipen, p	any situations where emergency treatment and/or medication (s) may ouffers/inhalers, Benadryl).
Instructions:	
	allergies:
b) Please list any food allergies:	
c) Any other allergies?	
	e are any activities in which your child cannot participate.
CHILD DEVELOPMENT	
Self Help: In what way does your child	need our help with the following self-help skills?
Dressing/Undressing:	
Eating:	
Toileting:	
Handwashing/Toothbrushing:	
Other: (ie: gross and fine motor skills)	
Are there any hints/suggestions you co positive one?	uld share with us to make your child's transition to the centre a
The "Good Things in Life": Tell us a few	things about your child
·	ok at books, listen to music, play with other children, play o, paint, computer/TV, imaginative play/dress-up)
Is there anything else you would like to	share with us about your child?

Name o	of child:	Date:	
PAREN <sup>®</sup>	TAL CONSENT FOR EME	GENCY CARE AND TRANSPORTATION	
authori	ze the operator/admin	nces such as an injury or sudden illness, medical treatment is necessary, I (we trator/staff of, to take whateve ary for the protection of (our) my child while in their care.	
	•	plying first aid, calling a physician or nurse, carrying out the instructions giver ld to a hospital, including the possible use of an emergency vehicle.	١,
	•	ecessary prior to contacting me (us) and that any expenses incurred for suc transportation is my (our) responsibility.	h
ADMIN	ISTRATION OF MEDICA	ON RECORD – Acetaminophen	
This au	thorizes staff of	to administer acetaminophen to	
(Name	of child)	providing the procedures outlined below have been taken.	
	At the first appearance	f symptoms (i.e. Fever), proceed as follows: (To be completed by the parent)	
1.	Take and record the chi	I's temperature and symptoms on the Potential Illness form.	-
	·	iscuss the symptoms and the child's temperature and to receive the parent ering acetaminophen. Be sure to have the parent confirm with you the dosag	
	Administer the medicat of Medication form.	on in accordance with the parent's directions and record on the Administratio	n
	•	signs the appropriate space on the Administration of Medication form upo are centre to confirm that he/she was consulted and is in agreement with th	
CONSE	NT FOR OUTINGS, EXCL	SIONS, ACTIVITIES OFF THE PREMISES OF THE DAY CARE FACILITY	
I		ne parent/guardian(s) of	
outings said vel I (we) ເ	, excursions and activitinicle are properly insure	trator/ staff of to take my (our) child o s away from the facility, either on foot or in a vehicle providing the driver an for the carrying of passengers. Ill receive advance notice of each planned outing, excursion, or activity awa	d
Parent	signature	Date	
Parent	signature	Date	