Appendix 1 - Child Profile

Early Learning and Childcare Facility
Child Profile

Registration Date_____ **Start Date**_____

Child's Name First		Last		Male ☐	Female ☐
Date of Birth	Medicare #	Expiry Date			
Address Street	Apt #	City/Town	Prov	Postal Code	
Parent/Guardian Name		Email Address		Home Telephone Number	
Address Street (if different from child's)	Apt #	City/Town	Prov	Postal Code	
Place of Work		Work Telephone Number		Cell Telephone Number	
Parent/Guardian Name		Email Address		Home Telephone Number	
Address Street (if different from child's)	Apt #	City/Town	Prov	Postal Code	
Place of Work		Work Telephone Number		Cell Telephone Number	
Child's Living Arrangement					

Other than you, who has permission to pick up your child?

Name	Relationship	Address	Daytime Telephone Number

If changing pick up arrangements parents must inform the facility prior to the child being picked up.

Is there anyone who does not have permission to pick up your child?
Name
Name
Name

Appropriate paperwork such as custody papers must be attached if a parent is not permitted to have contact with the child. Please discuss with the operator/administrator.

Two emergency contacts (other than parents/guardians) Must be able to respond within one hour if parent(s)/guardian(s) cannot be reached			
Name	Relationship	Address	Daytime Telephone Number

Child's health record

ALLERGY ALERT: **Please list any serious allergies**

_____ _____ _____

_____ _____ _____

Are any of the above allergies severe enough to require Epipen, medications, or emergency treatment?
Yes ☐ No ☐

If yes, please complete an Allergy Management and Emergency Plan available from the operator.

Please list any food, medication or contact allergies (non-life threatening)

Does your child require any essential routine services on a regular basis as part of a daily routine such as, catheterization, special hygiene procedures, on-going administration of medication, or ongoing observation of certain health conditions, such as diabetes, to determine when intervention is needed?
Yes ☐ No ☐

If yes, please complete an Essential Routine Services and Emergency Plan available from the operator.

Name of Medical Practitioner_____

Telephone Number _____

Address _____

Medical History: Please indicate if your child has **had** any of the following:					
	Yes	No		Yes	No
Measles			Rubella		
Mumps			Chicken Pox		
Meningitis			Pertussis (Whooping Cough)		

Health Status: Indicate if your child **has** any of the following:					
	Yes	No		Yes	No
Asthma			Diabetes		
Eczema/Psoriasis			Epilepsy/Seizures		
Other:			Other:		

Ongoing Medical Treatment: Please indicate any ongoing medical treatment your child may need (you will be required to complete an Administration of Medication form)

Name of medication	Dosage
Condition being treated	
Name of medication	Dosage
Condition being treated	

Immunizations: In accordance with subsection 12(2) of the *Reporting and Diseases Regulation - Public Health Act,* proof of immunization must be provided for each child attending an early learning and childcare facility for the following:

diptheria	rubella	mumps
tetanus	varicella	measles
polio	meningococcal disease	Haemophilus influenza type B
pertussis	pneumococcal disease	

Where proof is not provided you must have the following waivers:

- a medical exemption, on a form provided by the Minister of Health, that is signed by a medical practitioner or nurse practitioner, or
- a written statement, on a form provided by the Minister of Health, signed by the parent or legal guardian of his or her objections to the immunizations required by the Minister.

Note: Public Health will periodically review child files to ensure immunizations are complete or waivers are present.

Are there any activities in which your child cannot medically participate?

Please list any dietary restrictions (including those for medical, cultural, religious reasons):

Please advise the operator/administrator immediately of any changes to your child's health.

Preschool/childcare history

Has your child attended preschool/childcare before? Yes ☐ No ☐
If yes, for how long? 6 months ☐ 1 year ☐ 2 years ☐ more than 2 years ☐
If yes, please describe your child's experience:

Child development

Self Help: Does your child need help with the following? If yes, in what way?
Dressing/Undressing:
Eating:
Toileting:
Handwashing/Toothbrushing:
Other: (ie: gross and/or fine motor skills
Are there any hints/suggestions that will make your child's transition to the facility a positive one?
Tell us a few things about your child
What does your child like to do? (i.e.: look at books, listen to music, play with other children, play outdoors/indoors, toys, climb/run/jump, paint, computer, imaginative play/dress-up)
Is there anything else you would like to share with us about your child?

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

Information on this form is to be verified for accuracy annually.
Please immediately advise the operator/administrator of any changes.