

# Child's Health Resume (Required Form)

Child Care Regulation 36 requires every licensee to keep a record with respect to each child attending the facility that includes: (a) child's name and date of birth, (b) names, addresses and telephone numbers of the child's parents, persons to contact in the case of an emergency and the child's medical practitioner, (c) any allergies, illness or other medical condition and (d) the child's immunization status.

**Note: Personal health information may be disclosed by the facility to the Ministry of Education in the course of reviewing the facility's record keeping obligations.**

Child's Name: \_\_\_\_\_ Starting Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year Month Day

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year Month Day

**Parent/Guardian Name:** \_\_\_\_\_ **Parent/Guardian Name:** \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Place of business: \_\_\_\_\_ Place of business: \_\_\_\_\_

Business phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Are both parents listed above authorized to remove the child from the child care facility?  Yes  No

Comments: \_\_\_\_\_

**In case of emergency, the child care service will contact the following physician for medical treatment:**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Provide the names of two other persons to contact in case of emergency.**

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Business phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

## **Medical History**

Check (✓) any of the following illnesses which the child has had:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Earaches         | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Whooping cough               |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Injuries – please list _____ |
| <input type="checkbox"/> Chickenpox  | <input type="checkbox"/> Frequent colds   | <input type="checkbox"/> Polio           | _____   |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Influenza        | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other - please list _____    |
| <input type="checkbox"/> Croup       | <input type="checkbox"/> Measles (German) | <input type="checkbox"/> Scarlet fever   | _____   |
| <input type="checkbox"/> Diphtheria  | <input type="checkbox"/> Measles (red)    | <input type="checkbox"/> Tonsillitis     | _____   |

Are your child's immunizations up to date?  Yes  No

## **Allergies**

Does your child have any known **drug** allergies?  Yes  No If Yes, what are they, and what are your child's reactions?

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Does your child have any known **food** allergies?  Yes  No If Yes, what are they, and what are your child's reactions?

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Does your child have any **other** allergies?  Yes  No If Yes, what are they, and what are your child's reactions?

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## **Other Medical Information**

Does your child take any medication on a regular basis?  Yes  No If Yes, please give the name of the medication and the medical condition for which it is taken.

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Was your child born prematurely?  Yes  No If Yes, how many weeks?

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Do you have any concerns about your child's development?  Yes  No If Yes, please comment.

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Are there any restrictions on the kind and/or amount of physical activity in which your child may participate?

Yes  No If Yes, please identify.

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Has your child ever undergone surgery?  Yes  No If Yes, please list.

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Are there any special diets necessary for your child's health?  Yes  No If Yes, please describe.

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Please comment on any other medical information the child care service should be aware of.

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Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year      Month      Day

Parent/Guardian Signature