

# Child Health Record

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Doctor/Medical Information

Doctor's Name: _____ Telephone Number: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Date of most recent booster for DPTP: _____ Date of most recent booster for MMR: _____
Are there any physical or other problems that we should be aware of that may interfere with the child's full participation in the program or which may require special attention? (E.g. any symptoms indicative of ill health, injuries, operations, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include dates and details:
_____
_____

## History of Communicable Disease

Please indicate if your child has had any of the following:		
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rubella(German Measles)	<input type="checkbox"/> Hepatitis B

## Immunization Schedule

<p><b>A copy of your child's yellow immunization schedule is required.</b></p> <p><b>DPTP</b> (Diphtheria, Pertussis, Whooping Cough, Tetanus &amp; Polio) Complete Baby Needle Series at 2months, 4months, 6months, 16-18 Months &amp; 4-6 years</p> <p><b>Oral Polio (OPV):</b> (If applicable)</p> <p><b>MMR (Measles, Mumps, Rubella)</b> after 12 months <b>AND</b> at 18 months</p> <p><b>HIB</b> (Haemophilus Influenza, B) at 2 months, 4 months, 6 months &amp; 18 months</p> <p><b>TB Test:</b> Routine tuberculin test screening of children in low-risk populations is no longer required but is recommended. Please have your doctor determine if the tuberculin screening of your child is necessary. Indications for tuberculin skin testing in children include:</p> <ul style="list-style-type: none"><li>▪ Children who have lived or travelled for 3 months or more in an endemic area (where TB is prevalent) area or are recent immigrants from an endemic area (Asia, Middle East, Latin America, and Africa); or live in a household in which one of the household members lived or travelled for 3 months or more in an endemic area.</li><li>▪ Children who are aboriginal, living both on and off reserve.</li><li>▪ Children with HIV or living in a household with HIV-infected persons</li></ul>
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## Additional Information:

Please indicate any additional information:
<input type="checkbox"/> Skin Conditions: _____
<input type="checkbox"/> Sight Difficulties: _____
<input type="checkbox"/> Hearing Difficulties: _____

# Child Health Record

## Allergy(ies)

Allergies: If your child has an allergy(ies), please indicate below:

Allergy	Mild	Moderate	Severe	Life Threatening

If your child has a life threatening allergy please fill out Anaphylactic Shock and Allergic Reactions prior to start date (please ask Supervisor for copy). If allergy is not life threatening, please provide additional information:

\_\_\_\_\_

\_\_\_\_\_

Please indicate if you have completed Anaphylactic Shock and Allergic Reactions  Yes  No

## Medical Conditions

If your child has asthma or any other medical condition such as epilepsy, hemophilia, diabetes or reactions to drugs which could be a complicating factor please note this below and complete Medication/Treatment Record For Emergencies or Special Circumstances (please ask Supervisor for copy).

Please provide additional information: \_\_\_\_\_

\_\_\_\_\_

Please indicate if you have completed Medication/Treatment Record For Emergencies or Special Circumstances.  
Yes No

## Personal Information

I hereby consent to the collection, use and disclosure of my child's information by the centre for the purposes of providing child care services to my child enrolled in Centre programs. I understand that the Centre protects the privacy of all personal information in its possession in compliance with prevailing privacy legislation.

Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_