Upper Canada Child Care
Personal Information Form (Camp)

Please complete and sign this form. It can then be scanned and emailed to the centre supervisor or submitted in person.
Any changes to the information provided on this form must be submitted in writing to the centre supervisor immediately.

CAMP LOCATION:	**DATE:** (MM/DD/YY)	**REQUESTED START DATE:** (MM/DD/YY)

CHILD

First Name: ____________ Last Name: ____________ Date of Birth: ____________ (MM/DD/YY)

Address: ____________ Apt/Unit: ______ City/Town: ____________ Postal Code: ____________

Phone: ____________ Return client? ☐ N ☐ Y Sibling at another UCCC centre? ☐ N ☐ Y Centre Name: ____________

Transfer from another UCCC centre? ☐ N ☐ Y Centre Name: ____________

PARENT/GUARDIAN (Primary contact)

First Name: ____________ Last Name: ____________ Relationship: ____________

Address if different from child: ____________ Apt/Unit: ______ City/Town: ____________

Postal Code: ____________ Email: ____________

Cell Phone: ____________ Home Phone: ____________ Business Phone and Ext.: ____________

Business Name: ____________ Business Address: ____________

Unit: ____ City/Town: ____________ Postal Code: ____________

(Information must be provided for both parents/guardians, if applicable.)

PARENT/GUARDIAN

First Name: ____________ Last Name: ____________ Relationship: ____________

Address if different from child: ____________ Apt/Unit: ______ City/Town: ____________

Postal Code: ____________ Email: ____________

Cell Phone: ____________ Home Phone: ____________ Business Phone and Ext.: ____________

Business Name: ____________ Business Address: ____________

Unit: ____ City/Town: ____________ Postal Code: ____________

CUSTODIAL ARRANGEMENTS

Do temporary or final custody agreements (e.g. custody orders, domestic contracts, separation agreements) pertain to access to/visitation of your child? ☐ N ☐ Y If yes, please provide documentation at least two weeks prior to start date.

EMERGENCY CONTACT (Person, at least 16 years of age, authorized to pick up child. Photo ID matching information below is required.)

First Name: ____________ Last Name: ____________ Relationship: ____________

Address: ____________ Apt/Unit: ____ City/Town: ____________ Postal Code: ____________

Cell Phone: ____________ Home Phone: ____________ Business Phone and Ext.: ____________

EMERGENCY CONTACT (Person, at least 16 years of age, authorized to pick up child. Photo ID matching information below is required.)

First Name: ____________ Last Name: ____________ Relationship: ____________

Address: ____________ Apt/Unit: ____ City/Town: ____________ Postal Code: ____________

Cell Phone: ____________ Home Phone: ____________ Business Phone and Ext.: ____________

GENERAL TEMPERAMENT (Check all that apply.)
☐ Outgoing ☐ Shy ☐ Adaptable ☐ Struggles with change ☐ Very active ☐ Quiet ☐ Accepts limits ☐ Calm ☐ Anxious

HEALTH CARE PROVIDER
First Name: ____________ Last Name: ____________ Phone: ____________

Address: ____________ Unit: ______ City/Town: ____________ Postal Code: ____________

HISTORY OF COMMUNICABLE DISEASES (Please indicate if your child has had any of the following.)
☐ Chicken Pox ☐ Hepatitis B ☐ Measles ☐ Mumps ☐ Rubella (German Measles) ☐ Whooping Cough

IMMUNIZATION STATUS
☐ My child is immunized, and I have provided my child's school and/or local public health department with a current record of my child's immunizations.

☐ My child is not immunized and I have provided my child's school and/or local public health department with the required documents that outline medical exemption, or objections on the basis of conscience or religious beliefs.

FOOD SENSITIVITIES/DIETARY RESTRICTIONS (Add pages if needed.)
Does your child have food sensitivities? ☐ N ☐ Y Food sensitivities: ____________
Does your child have food sensitivities? ☐ N ☐ Y Dietary restrictions: ____________

ALLERGIES
Does your child have allergies (including to medications)? ☐ N ☐ Y If yes, please complete table below. (Add pages if needed).
If your child has life threatening allergies, please complete and return *Individualized Anaphylactic Action Plan* at least two weeks prior to start date.

Allergy	EpiPen required?	Typical reaction
	N ☐ Y ☐	
	N ☐ Y ☐	
	N ☐ Y ☐	
	N ☐ Y ☐	
	N ☐ Y ☐	

IDENTIFIED SUPPORT NEEDS
Does your child have medical conditions, diagnosed or undiagnosed, that may interfere with their full participation in the program? ☐ N ☐ Y If yes, please complete and return *Individualized Medical Plan* at least two weeks prior to start date.

Conditions: ____________

Does your child have any developmental disabilities or delays, or mental health conditions, diagnosed or undiagnosed, that may interfere with their full participation in the program? ☐ N ☐ Y If yes, please complete and return *Individualized Support Plan* at least two weeks prior to start date.

Conditions: ____________

Does your child currently receive support from external agencies (e.g. Speech and Language, Early Intervention)? ☐ N ☐ Y

Supports: ____________

Collection of Personal Information:
I hereby consent to the collection, use, and disclosure of information I provided to Upper Canada Child Care and its affiliated child care centres and programs, as well as external agencies responsible for quality assurance/inspection (e.g. Children's Services consultants) for the purpose of providing child care services. I understand that Upper Canada Child Care protects the privacy of all personal information in its possession in compliance with its *Confidentiality and Non-Disclosure Policy* and prevailing privacy legislation. By providing my email address on this form, I authorize email communication from Upper Canada Child Care and its affiliated child care centres and programs. I have read and understood this form.

____________________ ____________________
PARENT/GUARDIAN SIGNATURE **DATE (MM/DD/YY)**