



Child's Health Resume

(Required Form)

Child Care Regulation 35 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: _____ / _____ / _____ Personal Health Number: _____
Year Month Day

Group Medical Services or Medical Services Incorporated Number _____

Mother's name: _____ Father's 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 address: _____ Email address: _____

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: _____

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"/> Chicken pox | <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 | _____ |