Little Giants Childcare Centre
Beginning of greatness starts here.

Child Health Record

Child's Name: _____ Date: _____

Doctor/Medical Information

Doctor's Name: _____ Telephone #: _____

Address: _____

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. symptoms indicative of ill health, injuries, operations, etc.)

☐ Yes (If yes, please include dates and details) ☐ No

_____

History of Communicable Diseases

Please indicate if your child has had any of the following:

☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Whooping Cough ☐ Rubella (German Measles) ☐ Hepatitis B

Immunization Schedule

A copy of your child's yellow immunization schedule is required.

DPTP (Diphtheria, Pertussis, Whooping Cough, Tetanus & Polio): Complete Baby Needle Series at 2 months, 4 months, 6 months, 16-18 Months & 4-6 years
Oral Polio (OPV): (If applicable)
MMR (Measles, Mumps, Rubella): after 12 months AND at 4-6 years
HIB (Haemophilus Influenza, B): at 2 months, 4 months, 6 months & 18 months
TB Test: 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:

- 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.
- Children who are aboriginal, living both on and off reserve.
- Children with HIV or living in a household with HIV-infected persons

Additional Information

Please indicate any additional information which is relevant:

Skin: _____

Sight: _____

Hearing: _____

Other(s): _____

Allergies

If your child has any allergies, 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 have completed Medical/Treatment Record For Emergencies or Special Circumstances:

☐ Yes ☐ No

PARENT/GUARDIAN PERMISSIONS:

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.

Printed Name of Parent or Guardian: _____

Signature of Parent/Guardian: _____ Date: _____