CHILD PROFILE

Registration Date: _____ **Start Date:** _____

CHILD/FAMILY INFORMATION:

Name of child**:** _____ ˆMale ˆFemale

Date of Birth _____Medicare #: _____ Expiry date**:** _____

Name of Family Physician**:** _____ Telephone: _____

Address**:** _____

ALLERGY ALERT: Please list your child's allergies

_____ _____ _____

_____ _____ _____

Home Address: _____ Apt #_____

City_____ Postal Code _____

Phone#: _____Cell#**:**_____ E-mail**:**_____

Mother/Guardian Name**:** _____ Father/Guardian Name: _____

Place of work: (mother) _____Work Phone #: _____

Place of work: (father) _____Work Phone #: _____

Marital Status: Single Married Widowed Separated Divorced

With whom has the child lived for most of the past year? Mother Father Both Guardian Other (specify) _____

Who has permission to pick your child up from the center? _____

_____

_____

- If changing pick up arrangements parents(s) must call the center prior to the child being picked up.

Is there anyone who does not have permission to pick your child up from the center?

_____

What language(s) are spoken at home? English French Other (specify) _____

Siblings: Name _____ Age _____

Name_____ Age _____

Name _____ Age _____

Other people living in the home:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

EMERGENCY CONTACTS (not including parents/guardians)

1. Name _____ **Address:** _____

Telephone #: _____ **Relationship:** _____

2. Name _____ **Address:** _____

Telephone #: _____ **Relationship:** _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? Yes No

If yes, for how long? 6 months 1 year 2 years more than 2 years

Name of child's present or most recent preschool/child care center:

_____

_____

CHILD HEALTH RECORD

1. **Immunizations**: Please provide a copy of your child's immunization record. If for any reason your child has not received any or all of these immunizations appropriate to his/her age, please inform us.

   Parent(s) are responsible to update their child's immunization record and provide this to the facility as changes occur.

The dots (.) shown on this table illustrate the routine immunization schedule which should be followed for infants and children (less than 7 years)

Age	DPT-P/Hib	DPT-P	Hep. B	MMR	Td -P	Td
Birth						
2 months	.		.			
4 months	.					
6 months	.					
1 year			.	.		
18 months	.			.		
4-6 years		.				

DPT-P/hib – Diptheria, pertussis, tetanus, polio, haemophilus influenzae type b vaccine; DPT-P – Diptheria, pertussis, tetanus, polio vaccine; Hep.B - Hepatitis B vaccine; MMR – Measles, mumps, rubella vaccine; Td-P – Tetanus, diptheria, polio vaccine; Td – tetanus, diptheria vaccine

2. Medical History: Please indicate if your child has had any of the following**:**

	Yes	**No**
Measles		
Rubella		
Mumps		
Chicken Pox		
Meningitis		
Pertussis (Whooping cough)		

3a) Health Status: Please indicate if your child has any of the following**:**

	Yes	**No**
Asthma		
Diabetes		
Eczema/Psoriasis		
Epilepsy/seizures		
Other		

3b) Medical Treatment Please indicate medical treatment your child may require.

Name of Medication_____Dosage_____

Instructions**:**_____

_____

3c) **Emergency Treatment** Please indicate any situations where emergency treatment and/or medication(s) may be required by your child (i.e. Epipen, Benadryl)

Instructions**:** _____

_____

4. **Allergies** a) Please list any medication allergies _____

_____

_____

b) Please list any food allergies _____

c) Any other allergies? _____

5. **Additional information** Indicate if there are any activities in which your child **cannot participate.**

_____

_____

_____

CHILD DEVELOPMENT

To help us better understand your child, his interests and development, please assist us by completing the following.

1. **Child's Health at Birth**

Was your child more than 3 weeks premature? Yes No
If yes, how many weeks premature? _____

Did he/she stay in the hospital longer than the mother? Yes No
If yes, please explain

_____

Were there any difficulties with your child at the time of delivery? Yes No

If yes, please explain _____

_____

2. **Child's Health Since Birth**

EYES

Have you ever suspected that your child has vision problems?
(i.e. holding books too close, constant rubbing of his/her eyes, lazy eye) Yes No

If yes, please explain**:** _____

_____

_____

EARS

Has your child had frequent ear infections? Yes No

Have you ever suspected that your child has hearing problems? (i.e. turning volume up, lack of response to voice levels) Yes No

If yes, please explain: _____

_____

_____

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? Yes No

Has your child ever had any significant injuries for which he/she was hospitalized? Yes No

If yes, please explain**:**

_____

3. Child's Interests

A. Does your child:

- play with blocks, boxes, cups, or other Yes No
- construction toys without help? Yes No
- use crayons and/or markers to scribble or draw? Yes No
- listen to stories being read? Yes No
- turn pages of a book and look at pictures? Yes No
- recall stories or events? Yes No
- enjoy playing alone or with imaginary friends? Yes No
- talk with your friends/relatives who come to visit? Yes No

- follow simple, age-appropriate directions? Yes No

How many hours a day does your child spend watching TV? _____

Are there other things you would like to tell us about your child?

_____

_____

B. Self Help

In what way does your child need our help with the following self help skills?

Dressing/Undressing**:**

_____

Eating:

_____

Toileting:

_____

Handwashing/Toothbrushing: _____

Other: (i.e. gross and fine motor skills)

_____

How does your child communicate his needs/feelings?

_____

C. Sleeping Habits

What is your child's sleeping habits at home? (Usual bedtime; hours of sleep; napping; early riser; trouble sleeping or going to bed)

_____

Does your child require a "favorite something" to rest? What is it? Please feel free to send it with your child

_____

_____

D. Personality Traits

Describe your child's personality (i.e. trusting, shy, angry, happy, sad, curious, active, anxious, fearful, affectionate)

_____

_____

Has your child had opportunities to play with other children? (i.e. church, neighbours, play groups, relatives)? Yes No

Further comments: _____

Does your child make friends easily? Yes No
Please explain:

_____

_____

How does your child respond to adults?

_____

_____

How does your child respond to change? (i.e. separation from parents/guardians, routine transitions, scheduling, introduction of new foods)

_____

_____

Are there any hints/suggestions you could share with us to make your child's transition to the centre a positive one?

_____

_____

_____

_____

E. The "Good Things in Life"

What does your child like to do? (i.e. look at books, listen to music, play with other children, play outdoors/indoors, toys, climb/run/jump, paint, computer/TV, imaginative play/dress-up)

_____

_____

_____

What doesn't your child like to do?

_____

_____

_____

The time I enjoy best during the day with my child is:

_____

_____

Because:

_____

The thing that frustrates me most in trying to care for my child is:_____

_____

Because: _____

I would describe my child as: _____

_____

_____

What I like best about my child is:

_____

_____

_____

What concerns me most about my child is:

_____

_____

_____

One of our favorite family activities is:

_____

_____

General comments: i.e. expectations

_____

_____

_____

OFFICE USE

Start date: _____

Visit date (child and parent):_____

Withdrawal date: _____

Notable Changes: _____

_____

_____

_____

_____

_____

_____

_____