Upper Canada Child Care

Personal Information Form (Camp)

Please complete and submit form to centre supervisor. Any changes must be submitted in writing.

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

Transfer from other UCCC centre?	N	Y	Name of centre transferred from:
	☐	☐	

Sibling at other UCCC centre?	N	Y	Name of centre sibling attends:
	☐	☐	

PARENT/GUARDIAN (Primary contact)

First Name:	Last Name:	Relationship:

Address same as child?	N	Y	Address if different:	Apt/Unit:
	☐	☐		

City/Town:	Postal Code:	Email:

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

Business Name:	Business Address:

Unit:	City/Town:	Postal Code:

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

First Name:	Last Name:	Relationship:

Address same as child?	N	Y	Address if different:	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? If yes, please provide documentation at least two weeks prior to start date.	N	Y
	☐	☐

EMERGENCY CONTACT (Person at least 16 years of age authorized to pick up child; photo ID matching information below 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 required)

First Name:	Last Name:	Relationship:	
Address:	Apt/Unit:	City/Town:	
Postal Code:	Cell Phone:	Home Phone:	Business Phone and Ext.:

GENERAL TEMPERAMENT (Please check all that apply)

Outgoing	Shy	Adaptable	Struggles with change	Very active	Quiet	Accepts limits	Calm	Anxious
☐	☐	☐	☐	☐	☐	☐	☐	☐

HEALTH CARE PROVIDER

First Name:	Last Name:	Address:	
Unit:	City/Town:	Postal Code:	Phone:

IMMUNIZATION STATUS (Please check one):

☐ 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.

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
☐	☐	☐	☐	☐	☐

FOOD SENSITIVITIES/DIETARY RESTRICTIONS

Does your child have food sensitivities?	N	Y
	☐	☐

Please list food sensitivities:		
Does your child have dietary restrictions?	**N** ☐	**Y** ☐
Please list dietary restrictions:		

ALLERGIES

Does your child have allergies (including to medications)? 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.	**N** ☐	**Y** ☐

Allergy	EpiPen required?		Typical reaction
	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? If yes, please complete and return *Individualized Medical Plan* at least two weeks prior to start date.	**N** ☐	**Y** ☐
Please list 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? If yes, please complete and return *Individualized Support Plan* at least two weeks prior to start date.	**N** ☐	**Y** ☐
Please list conditions:		
Does your child currently receive support from external agencies (e.g. Speech and Language, Early Intervention)?	**N** ☐	**Y** ☐
Please list 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)**