Upper Canada Child Care

Personal Information Form

Please complete and sign this form. Scan and email to the centre supervisor or submit in person. Notify supervisor in writing immediately if there are any changes to the information provided on this form.

CENTRE:	**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: _____

PROGRAM (Note: not all programs are offered at each centre.)

○ Infant ○ Toddler ○ Preschool ○ Nursery school ○ Before school only ○ After school only ○ Before and after school

○ My child requires full time care (five days per week) **OR** ○ My child requires part time care (requires a minimum of two days per week on a consistent schedule check appropriate days)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

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: _____

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

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

Are there temporary or final custody agreements (e.g. custody orders, domestic contracts, separation agreements) concerning access to/visitation of your child? ○ **N** ○ **Y** If yes, please provide documentation two weeks prior to start date.

EMERGENCY CONTACT (Person, at least 16 years of age, authorized to pick up child. Photo ID matching the 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 the 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 ☐Highly sensitive to stimuli

SOCIAL/EMOTIONAL

Most recent child care: ◯Parent/guardian ◯Relative(s) ◯Private home care ◯Licensed child care

Typical play: ☐Prefers to play alone ☐Plays beside others ☐Plays with others

Are there fears or life events that may be affecting your child (e.g. losses, changes)? ◯**N** ◯**Y** If yes please comment:

How is your child comforted?

COMMUNICATION SKILLS

◯Non-verbal ◯Uses words ◯Uses sentences Other:

Languages spoken: Languages spoken at home:

SELF-HELP SKILLS

Feeding: ◯Self ◯Assisted ◯Adventurous eater ◯Particular eater **Toileting:** ◯Self ◯Assisted ◯Wears diapers

Napping: ◯Does not nap ◯Usually naps **Dressing:** ◯Self ◯Assisted

Self-Regulating (e.g. able to self-calm after an upset): ◯Consistently ◯Developing ◯Not yet observed

Additional Information (e.g. comments, strategies):

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

Before-and-After-School Programs Check one:

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

OR

◯My child is not immunized and I have provided the 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.

Infant, Toddler, or Preschool Programs Check one:

◯My child is immunized and I am including a copy of my child's immunization record with this form.

OR

◯My child is not immunized, and I am including a signed *Statement of Medical Exemption* with this form.

OR

◯My child is not immunized, and I am including a signed affidavit of *Statement of Conscience or Religious Belief* with this form.

FOOD SENSITIVITIES/DIETARY RESTRICTIONS (Add pages if needed.)

Does your child have food sensitivities? ◯**N** ◯**Y** Food sensitivities:

Does your child have dietary restrictions? ◯**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.)

Does your child have life-threatening allergies? ◯ N ◯ Y If yes, please complete *Individualized Anaphylactic Action Plan* prior to start date, as soon as possible.

Allergy	Epipen required?	Typical reaction
	◯ N ◯ Y	
	◯ N ◯ Y	
	◯ N ◯ Y	

IDENTIFIED SUPPORT NEEDS

Does your child have any medical conditions, diagnosed or undiagnosed, that may interfere with their full participation in the program or which may require special accommodation? ◯ N ◯ Y If yes, complete Individualized Medical Plan prior to start date if possible.

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 or which may require special accommodation? ◯ N ◯ Y If yes, please complete *Individualized Support Plan* in collaboration with the centre.

Conditions:

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

Supports:

For information on our collection and use of personal information, please review UCCC Child Care Privacy Policy available on request and on the UCCC website (uppercanadachildcare.com/resources/).

PARENT/GUARDIAN SIGNATURE

DATE
(MM/DD/YY)