York University Co-operative Daycare Centre

Medical History

Child's First Name: _____ **Child's Last Name:** _____

Date of Birth: _____ **Male** ☐ **Female** ☐ **Other** ☐ _____

MEDICAL INFORMATION

The physician's name will follow as we are new to the country/area. [ ]

Physician's Name: _____ **Health Card #:** _____

Address: _____ **City:** _____ **Postal Code:** _____ **Phone #:** _____

In the event of a medical emergency where medical treatment is necessary and YUCDC does not have your child's Health Card Number, YUCDC will pay the applicable fees with the understanding that you will reimburse YUCDC in full.

IMMUNIZATION RECORD: Please attach a copy of your child's current immunization record.

☐ I/We have chosen not to immunize. Please be advised that to protect your child, he/she will be excluded from attending the program if an outbreak should occur. As indicated in our Absence from Care Procedure, a refund will not be given for days missed.

Emergency Medication: EpiPen ☐ Puffers ☐ Other ☐ _____

If your child requires the administration of any Emergency Medication, an Emergency Plan and/or note stating the symptoms and dosage of medication from your child's physician will be required prior to his/her start date.

SPECIAL REQUIREMENTS REGARDING DIET, REST AND/OR EXERCISE

Environmental Allergies: ☐ Yes ☐ No

Details, if YES:

Food Allergies: ☐ Yes ☐ No

Details, if YES:

Dietary Restrictions: ☐ Yes ☐ No

Details, if YES:

Other: ☐ Yes ☐ No

Details, if YES:

Special Diet Required: ☐ Non-Applicable ☐ Kosher ☐ Vegan ☐ Gluten-Free ☐ Dairy-Free
☐ Halal ☐ Vegetarian ☐ Egg-Free ☐ Other: _____

Has your child had the following communicable diseases?			
☐ Chicken Pox	☐ German Measles	☐ Hepatitis	☐ Mononucleosis
☐ Mumps	☐ Scarlet Fever	☐ Whooping Cough	☐ Other

OTHER HEALTH DETAILS (Please check any applicable areas)			
☐ Asthma	☐ Autism Spectrum	☐ Diabetes	☐ Speech & Language
Medication administered on a regular or emergency basis:			
Other:			

→ Will any of the above conditions limit or affect participation in activities? Yes ☐ No ☐ If yes, please specify: _____

_____

_____

→ Does your child have any other medical conditions (including behavioural/support)? Yes ☐ No ☐
If yes, please specify: _____

_____

→ Recent illness, operations, or injuries: _____

→ Please provide any additional information that you feel would assist us when caring for your child. _____

_____

_____

AUTHORIZATION TO REGISTER

In registering, I understand that in the event of a medical emergency, my child may be required to seek immediate medical attention and may be transported to seek treatment by approved medical personnel. Treatment may include: administration of drugs, anaesthetics, blood transfusions, injections, or any other treatment as noted to be recommended by the medical personnel caring for my/our child.

_____ _____ _____

Date **Parent/Guardian Signature** **Parent/Guardian Signature**