WEST END HOME CHILD CARE SERVICES
1411 Bloor Street West, Toronto, Ontario M6P 3L4 • Tel: (416) 537-4154 • Fax: (416) 537-2740

Child File Index

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Child's Name | Birth Date (dd/mm/year) | File #

Parent/ Guardians Name | Parent/ Guardians Name

Home address and postal code | Home address and postal code

Home phone # | Home phone #

Email | Email

Cell/Pager # | Cell/Pager #

Work/School address and postal code | Work/School address and postal code.

Work/School phone # | Work/School phone #

Doctor's Name | Doctor's Address | Doctor's Telephone Number

Court/Custody Order on File: YES NO (If yes please provide to office)

FIRST PERSON TO CALL IN CASE OF EMERGENCY (OTHER THAN THE PARENT/GUARDIANS)

YES ☐ NO ☐

Name | Relationship to child | Home Phone # | Authorized to pick up

Address | Postal Code

Other people authorized to pick up

Name | Relationship to child | Home Phone #

Name | Relationship to child | Home Phone #

Parents/Guardians Signature | **Home Consultant** | **Date**

Date of admission | **Deposit paid** | **Daily Fee** | **Date of withdrawal**

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INITIAL PARENT/GUARDIAN INTERVIEW

Child Name: _____

Parent's/ Guardians Name: _____

Sleeping Patterns: _____

E.g.: Tummy, Side, on back etc., naps, does not nap

Does your child have a security item? _____

E.g.: Bottle, blanket, bear, pacifier, sucking thumb etc.

Feeding: General information about eating habits or food restriction: _____

Circle what the child eats: Water, Juice, Fruits, Vegetables, Meat, and Cereal

Child's attitude towards eating is generally good – or – bad? Explain: _____

Language(s) spoken at home, cultural interests: _____

Needs and Abilities: _____

Is your child talking, comprehending? _____

Circle the activities the child enjoys: Toys/ Games/ Music/ Stories/ Books/ Dramatic play/ Songs.

What method of discipline do you use in your home? _____

How many daycare arrangements has the child had? _____

Does your child have any fears? _____

Reaction to fear: _____How do you manage it: _____

What frustrates your child: _____

How do you manage it? _____

CHILD'S DAILY SCHEDULE

Please complete the child's morning/afternoon routine and schedule. By providing this information the provider will have a better understanding of your child's day (i.e., naps, play schedule, eating schedule and time spent outdoors)

MORNING: **AFTERNOON:**

_____ _____

_____ _____

_____ _____

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MEDICAL AND HEALTH CARE INFORMATION (MEDICAL RELEASE)

Child's Name: _____ Date of Birth: _____

General Health: _____

Does your child have any allergies? _____ Epi pen required. _____
E.g., Food, clothing, animals, play materials, drugs, other.

Please specify symptoms, signs to look for: _____

Treatment for allergy: _____

Birthmarks: _____

Is your child Asthmatic? _____ Is your child on puffer? _____

Date of last examination: (y/m/d) **_____ Current weight**: _____

At the present time is the child free of communicable diseases? _____

List previous history of communicable diseases in the past. _____

_____

Please describe specific requirements for diet, rest, or exercise, if applicable:_____

_____

MEDICATION

The provider will administer only prescription medication as required. All medication must come in the original container with the prescription label. Parents/ Guardians must sign their consent for the administration of such medication. In addition, the provider will document all medication on the appropriate form.

PARENTS CONSENT FOR MEDICAL TREATMENT

Note: If at anytime, due to such circumstances as accident, sudden illness or emergency, medical treatment is required, this may be given, including anesthetic, if necessary, by a private physician or hospital.

In the event of a medical emergency, the child named above will be transported by ambulance and/or taxi to a hospital and/or physician's office by a home provider.

_____ _____ _____

Parents/Guardians Signature **Home Consultant** **Date**

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DIAPERING, SUN BLOCK

I parent/guardian of the following named child _____ authorize the provider of West End Home Child Care Services to use the following diapering and sun block products on my child when required.

Sun block to be used: _____Anything provided by parent_____

Diapers, wipes, and creams to be used: _____Anything provided by parent_____

Diapering Instructions: _____

_____ _____ _____

Parents/Guardians Signature **Home Consultant** **Date**

HAND SANITIZING

I _____parent of _____, give my permission to West End Home Child Care Services provider care to use Sanitizer provided by the day care to sanitize my child's hands when water is not available (trips, parks, playgrounds).

_____ _____ _____

Parents/Guardians Signature **Home Consultant** **Date**

PARENT/GUARDIAN CONSENT FOR ALTERNATIVE SLEEP

* *All infants under the age of 18 months will be sleeping in a playpen or a crib while in the provider's home**

I _____, parent/guardian of the following named child _____ give my consent for my child over the age of 18 months to sleep in an alternative way which may include a mat on the floor, a bed, a cot while in the provider's home. Alternate sleep arrangement please provide description of the sleep accommodation requested: _____.

(Please leave blank if not applicable)

_____ _____ _____

Parents/Guardians Signature **Home Consultant** **Date**

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PHOTOGRAPH CONSENT & AUTHORIZATION

I _____parent/ guardian of the following child_____
hereby consent to have my child photograph taken by the Provider of the home childcare. To be used for informing and updating the parents/ guardians throughout the day. Photographs are also used for displays and identification within the home and shared with West End Home Childcare Services.
Photographs are sent to families via WhatsApp. (Providers are prohibited to post or share photographs across any other social network.)

Photographs are also taken in a group setting. I _____ parent/ guardian GIVE consent to share group photos with other parent in West End Home Childcare Via WhatsApp group.

I _____ parent/ guardian DO NOT consent to share group photos with other parent in West End Home Childcare Via WhatsApp group.

_____ _____ _____
Parents/Guardians Signature **Home Consultant** **Date**

DISCLOSURE OF INFORMATION POLICY/CONFIDENTIALITY CONSENT FORM

To provide quality care for children, there are times when it is appropriate for the School, Child Care, Toronto Children's Services, or the Family Resource Program to exchange information. The kind of information shared may include, but is not limited to, matters involving attendance, illness, transportation, or behaviour.

I _____ hereby consent to West End Home Child Care and _____ (School) and/or resource teachers and/or Toronto Children's Services for the reciprocal exchange of information about my child _____ born on _____.

_____ _____ _____
Parents/Guardians Signature Home Consultant Date

PARENT/GUARDIAN CONSENT FOR ALTERNATIVE CARE

I _____, parent/guardian of the following named child_____

- Give my consent to any adult residing in the home _____, and or any W.E Home Consultant. Provider's name _____ to look after my child while the provider of West End Home Child Care is out of the home. (E.g., school pick up or drop off during inclement weather, emergency,)
- Do not give consent to anyone other than the primary caregiver or Home Consultant to care for my child.

_____ _____ _____
Parents/Guardians Signature **Home Consultant** **Date**

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OUTDOOR PLAY SUPERVISION PLAN AND AUTHORIZATION

Outdoor play is supervised to a written plan that's agreed upon by the parent, provider and West End Home consultant. (s.30).
Each child over the age of 30 months who attends the home childcare program for six (6) or more hours in a day, shall have at least two (2) hours of outdoor play time per day. Weather permitting. unless the parent or a physician otherwise in writing (s.47(4)

I _____parent/guardian of the following named child_____

Hereby consent to have the said child use the outdoor space on premises of the provider's home under the provider's supervision. (if back-up care is required, I give permission for the said child to use the outdoor space on premises of the provider's home under the provider's supervision)

Outdoor Space _____. (Front yard, Back yard or both)

TRAVEL CONSENT PARENTS AUTHORIZATION

I _____ parent/guardian of the following named child _____
Hereby consent to have the said child leave the premises of the provider's home under the provider's supervision to participate in daily outings, trips to parks, playgrounds, libraries and Early-On Program.
I allow my child to go on these outings on foot or TTC.

** Any Field Trips involving TTC will have a separate permission form to be completed and signed by parent**

SCHOOL ESCORT / SCHOOL TRANSPORTATION

I _____ parent/guardian of the following named child _____
hereby give my consent for my set child to walk, to and from school, escorted by the childcare provider.
School pick up and drop off school-age children /all enrolled children in care. (Provider who Providers Before and after school care).

OTHER SUPERVISION REQUIREMENTS (if applicable)

Please list additional plans and /or requirements for outdoor supervision based on the child's age and individual needs.

_____

_____

_____

_____	_____	_____	_____
Parents/Guardians signature	**Home Consultant**	**Date**	**Provider**

Revised December 2, 2024, 2024.

TORONTO Public Health

East York Civic Centre
850 Coxwell Avenue
Toronto, Ontario
M4C 5R1
Fax: 416-338-2487

Request for Immunization Information for New Registrants of Day Nurseries

To Parents/Guardians:

Please complete the information below or attach a copy of your child's immunization record. You can get your child's immunization record from your doctor. Please return this form to the Licensed Child Care Provider within two weeks. Detailed instructions are on the back of this form. If you require further information, call the Toronto Public Health Immunization Information Line at **416-392-1250**.

IT IS IMPORTANT TO COMPLETE THIS INFORMATION IN FULL (PLEASE PRINT CLEARLY):

Facility Name: _____

Child's Name: _____
SURNAME MIDDLE NAME FIRST NAME

Date of Birth: _____ Gender: Male Female Other (CIRCLE ONE)
(yyyy/mm/dd)

ONTARIO HEALTH CARD NUMBER |_|_|_|_|_|_|_|_|_|_|

Home Address: _____
NUMBER STREET NAME UNIT # CITY POSTAL CODE

Parent/Guardian Name: _____
SURNAME GIVEN NAME

Telephone Number: _____
HOME BUSINESS

Doctor's Name: _____ Doctor's Telephone Number: _____

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD OR COMPLETE THE SECTION BELOW

Vaccine / Dates Given (yy/mm/dd)	Diphtheria	Tetanus	Pertussis (Whooping Cough)	Polio	Haemophilus B (HIB)	Pneumococcal	Rotavirus	Measles	Mumps	Rubella (German Measles)	Meningococcal	Varicella (Chickenpox)	Hepatitis B	BCG	Other immunizations, tests results or comments

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 7. It is used for the Toronto Public Health Vaccine Preventable Diseases Program. **The confidentiality of this information is protected.** For more information, visit our Privacy Statement at www.toronto.ca/health/information_practice_statement.htm **or** contact Manager, Vaccine Preventable Diseases - 850 Coxwell Avenue, Toronto, ON, M4C 5R1 or by telephone: 416-392-1250.

Please see other side

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MEETING CHILD'S INDIVIDUAL NEEDS

Child's Name:	D.O.B.
Date Originally created:	Date updated parent initials :
Arrival Time: Does this child require any special assistance when arriving to help with separation from their parents?	If this box is left blank, it is assumed that no special accommodations are required.
Indoor/outdoor clothing: Does your child have any specific clothing requirements.	If this box is left blank, it is assumed that no special accommodations are required.
Outings: Does your child require any additional attention during outings.	If this box is left blank, it is assumed that no special accommodations are required.
Departure Time: Does this child require any special assistance when preparing to go home? Has the parent requested any specific information be provided at the end of the day?	If this box is left blank, it is assumed that no special accommodations are required.

Additional Notes: _____

_____

_____

_____

Parent/Guardian Signature:

Date:

This file has been reviewed and understood by Provider Name _____ Signature _____

Date: