Note: Personal health information may be disclosed by the facility to the Ministry of Education in the course of reviewing the facility's record keeping obligations.

Child's name: _____ Starting Date: _____/_____/_____
Year Month Day

Date of Birth: _____/_____/_____ Personal Health Number: _____
Year Month Day

Group Medical Services or Medical Services Incorporated Number _____

_____	_____
Home Address: _____	Home Address: _____
Postal Code: _____	Postal Code: _____
Home phone: _____	Home phone: _____
Place of business: _____	Place of business: _____
Business phone: _____	Business phone: _____
Cell phone: _____	Cell phone: _____
Email address: _____	Email address: _____

Does your child have any known allergies? Yes No If Yes, what are they and what are your child's reactions?

_____

Doda_____