Centre de santé communautaire de Timmins
CSCTimmins.ca

CHILD REGISTRATION FORMS (UNDER 14 YEARS) – PRIMARY CARE

Personal details – Mandatory section Please write the name as it appears on your health card					
Surname	First name	Date of birth dd / mm / yyyy	Identify as male ☐	Identify as female ☐	Identify as other ☐
Address		City		Postal Code	
Residential Telephone		Work Telephone		Cellular Telephone	
Name of parent/Responsible adult:			Food allergies		
Email address of responsible parent: _____ CSCT uses email for some communications. You will receive an email consent form to complete after your registration.					
Health Card					
Card number		Version		Expiration date dd / mm / yyyy	
In case of emergency					
Contact person	Relation		Telephone 1	Telephone 2	
Pharmacy					
Name of your pharmacy			City		
Third party insurance					
Do you have insurance coverage?	☐ Yes	☐ No	Name of insurance provider		

Language
Language of origin : ☐ French ☐ English Other: _____ Preferred spoken language with health care provider: ☐ French ☐ English

By submitting this registration form you will be added to our wait list.

Parent Signature _____ **Date** _____

PERSONAL HEALTH FORM – CHILD (0-13YEARS)

Surname	**First Name**	**Date of birth** dd/mm/yyyy
Name of your previous physician or nurse practitioner:		**Approximate date of your last appointment:**
Height (cm or feet):	**Weight (lbs or kg):**	

FAMILY SITUATION
Civil status of parents: □ Single □ Common law/Married □ Separated/Divorced □ Remarried Child lives with: □Both parents □Mainly mother □ Mainly father □ Shared □ Other (please specify): Does anyone smoke in the home: □ No □ Yes: who? _____ Does the child follow a special diet? □ No □ Yes : which? _____ Does the child attend daycare: □ No □ Yes : which? _____

PERSONAL HEALTH

Birth history (to be completed if child is less than 2 years of age)
Birth weight: _____ Length: _____ Birth: □ Vaginal □ Cesarian Complications during pregnancy or birth?

Current and passed health history
Has your child been diagnosed with a physical or mental health problem by another care provider (examples: anxiety, attention deficit disorder, etc.?) If yes, which? _____ _____ _____ Do you have concerns with your child's development: □ No □ Yes
Is your child followed by a specialist or a pediatrician? Name of specialist: _____ □ Currently □ In the past Reason(s) _____

Surgeries or hospitalisations		
Type of surgery or reason for hospitalisation	Year or age	Hospital

Immunisations:	**Please provide a copy of child's immunisation booklet**

Medications: (include drops and prescribed creams/ointments)		
Name	Dose	How many times a day
Non prescribed medications (vitamins, natural supplements and over the counter pain medications)		

Allergies: (medications, latex, or foods)	
Name	Reaction

Family medical history			
Family members		Age	Health problems (examples): diabetes, high blood pressure, high cholesterol, heart conditions, stroke, Cancer (type), mental health disorders, etc.
Mother	□ Living □ Deceased		
Father	□ Living □ Deceased		
Maternal grand mother	□ Living □ Deceased		
Maternal grand father	□ Living □ Deceased		
Paternal grand mother	□ Living □ Deceased		
Paternal grand father	□ Living □ Deceased		
Siblings	□ ___ Brothers □ ___ Sisters		