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		

CENTRE DE SANTÉ COMMUNAUTAIRE DE TIMMINS **SOINS PRIMAIRES**	
1500 Riverside Drive, Unit 58	
Timmins, ON, P4R 1A1	
(Timmins Square)	
TELEPHONE: 705-269-2728	
FAX: 705-269-2729	
Office hours **Monday to Friday** 9h à 12h - 13h à 16h	**Telephone services** **Monday to Thursday** 9h to 12h - 13h to 15h00 **Friday** 9h to 12h

Socio-demographic information – Mandatory section

Socio-economic

Gender identity:	**Sexual orientation:**
☐ Male	☐ Bisexual
☐ Female	☐ Homosexual
☐ Intersex	☐ Heterosexual
☐ Trans – Female to Male	☐ Lesbian
☐ Trans – Male to Female	☐ Queer
☐ Two-Spirit	☐ Two-Spirit
☐ Other (Specify): _____	☐ Other (Specify): _____
☐ Do not know	☐ Do not know
☐ Prefer not to answer	☐ Prefer not to answer
Highest education level attained	**Combined annual household income:**
☐ Too young for primary completion	☐ 0$ à 14 999$
☐ Primary (grades 1-8)	☐ 15 000$ to 19 999$
☐ Secondary or equivalent	☐ 20 000$ to 24 999$
☐ College	☐ 25 000$ to 29 999$
☐ University Bachelor's	☐ 30 000$ to 34 999$
☐ University Post-Graduate	☐ 35 000$ to 39 999$
☐ No formal education	☐ 40 000$ to 59 999$
☐ Other (Specify): _____	☐ 60 000$ to 89 999$
☐ Do not know	☐ 90 000$ to 119 999$
☐ Prefer not to answer	☐ 120 000$ to 149 999$
	☐ 150 000$ or more
	☐ Do not know
	☐ Prefer not to answer
No. of people supported by income: _____	**Current household composition:**
☐ Prefer not to answer	☐ Couple with children
	☐ Couple without children
	☐ Sole member
	☐ Grandparents with grandchild(ren)
Homeless status:	☐ Extended family
☐ Not homeless	☐ Unrelated housemates
☐ Homeless/No address	☐ Siblings
☐ Shelter	☐ Single parent
☐ Other temporary housing	☐ Do not know
	☐ Prefer not to answer

Language

Spoken language (preferred)

- ☐ French
- ☐ English
- ☐ Other: _____

Language of origin:

- ☐ French
- ☐ English
- ☐ Other: _____

Official Canadian languages:

- ☐ French
- ☐ English

If your language of origin is neither French nor English, in which of Canada's official languages are you more comfortable?

Other languages spoken:

_____

_____

_____

Interpreter required for appointments: ☐ Yes ☐ No

Background

Racial or ethnic group:

- ☐ Asian – East
- ☐ Asian – South
- ☐ Asian – South East
- ☐ Black – African
- ☐ Black – Caribbean
- ☐ Black – North American
- ☐ First Nations
- ☐ Indian – Caribbean
- ☐ Indigenous/Aboriginal
- ☐ Inuit
- ☐ Latin American
- ☐ Metis
- ☐ Middle Eastern
- ☐ White – European
- ☐ White – North American
- ☐ Mixed Heritage
- ☐ Other (Specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

Country of origin:

- ☐ Canada
- ☐ Other country (Specify): _____

Year of arrival in Canada: _____

Religion:

- ☐ Catholic
- ☐ Protestant
- ☐ Christian Orthodox
- ☐ Christian
- ☐ Muslim
- ☐ Jewish
- ☐ Buddhist
- ☐ Mennonite
- ☐ Hindu
- ☐ Sikh
- ☐ Eastern religion
- ☐ No religious affiliation
- ☐ Other (Specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

Disability (check all that apply)

☐	None	☐	Physical disability
☐	Chronic illness	☐	Sensory disability
☐	Developmental disability	☐	Other: _____
☐	Drug or alcohol dependence	☐	Do not know
☐	Learning disability	☐	Prefer not to answer
☐	Mental illness		Physical disability

Wellbeing

What is you sense of **belonging to the community**?

☐	Very Strong	☐	Somewhat Strong	☐	Somewhat weak	☐	Very weak	☐	Do not know	☐	Prefer not to

In general, how do you feel about the state of your **physical health?**

☐	Excellent	☐	Very good	☐	Good	☐	Fair	☐	Poor	☐	Do not know	☐	Prefer not to answer

In general, how do you feel about the state of your **mental health?**

☐	Excellent	☐	Very good	☐	Good	☐	Fair	☐	Poor	☐	Do not know	☐	Prefer not to answer

The CSCT is engaged to be sensitive to and prevent obstacles to accessibility to our programs and services for people with disabilities

Please indicate if you have any **special needs**:

☐	Deaf or hard of hearing	☐	Intellectual disability
☐	Mental health disorder	☐	Physical handicap / Motor deficiency
☐	Difficulty in speech and language	☐	Visual deficiency
☐	Assistance animal	☐	Difficulties with reading and writing

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

LIFESTYLE HABITS	
Exercise	Does your child exercise regularly? ☐ Yes ☐ No If yes, what type?

PREVENTION

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		

Do you have other pertinent information to share about the health of your child? You will also be able to discuss this during your first appointment.

Parent signature: _____ **Date _____**

ORIENTATION GUIDE

1. **Eligibility**
   - Ability to understand, read and write in French (ex: consent)
   - In the event that the client is unilingual, to be eligible for our services, he or she must have a link with an immediate family member (partner or child) of a client already registered with the Centre de santé Communautaire de Timmins (CSCTimmins).

2. **Becoming a client**
   - Please be advised that you are a client of CSCTimmins and not a client of a specific doctor or nurse practitioner.
   - Access to all members of the interdisciplinary team (ex. registered nurse, dietitian, social worker) for continuity of care as needed. This increases the accessibility of our services and this model is put into practice to better serve our clients and their identified needs.

3. **Interdisciplinary Team**
   - The CSCTimmins client will have access to all services in French in the primary care clinic as well as all community activities.
   - If you are not a primary care client, you still have access to community programs, activities and workshops.

4. **Appointments**
   - You must contact the office at least 24 hours prior to your appointment to notify the staff of your cancelation; not only for the clinic but for all service appointments.
   - If you are more than 15 minutes late for your scheduled appointment, your appointment will be canceled and considered a “no show”.
   - After your 3rd missed appointment without notification, a letter of notice will be sent to you by mail. If there is no response, your file will be closed. If you choose to contact us for services, your name will be added to our wait list to become a client.

5. **Prescription Renewal**
   - You should contact your pharmacy **1 to 2 weeks** prior to your medication running out for a refill.

I confirm that I have read and understand the Client Orientation Guide as well as the procedure listed. As a client of the Centre de santé communautaire de Timmins, I accept responsibility for the terms stated above and understand what this guide states.

Parent Signature _____ **Date** _____

Print name _____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF CLIENTS PERSONAL INFORMATION

The Centre de santé communautaire de Timmins (CSCT) recognizes the importance of protecting your personal information and commits to collect, use and disclose your personal information in a honest and legal way by implementing good personal information protection practices, including information given to a third party.

The CSCT collects, uses and discloses the information to:

- Provide and manage secure primary health care services;
- Establish and assure ongoing and effective health services;
- Communicate with other service providers (with your consent);
- Provide community and health promotion services;
- Inform certain funding bodies such as Ontario's Ministry of Health and Ministry of Long-Term Care and the Local Health Intergration Networks in order to contribute to the planning et management of the health care system;
- Evaluate and plan your health needs;
- Establish and maintain communication with you;
- Manage the administrative operations of the CSCT;
- Participate in the research to improve the quality of health services or use the data collected for specific reseach purposes;

Respond to any other objective permitted or required by law (for exemple: reporting infectious diseases to Public Health).

You acknowledge that you have given an informed consent regarding the collection, use and disclosure of your personal information for the reasons listed above. If a new reason for the use or disclosure of your personal information appears, we will notify you and seek your consent beforehand.

You may ask to see and make changes to your personal information regarding your health. You can withdraw your consent to the use and disclose of your personal information at any time upon notice; at that time, the CSCT will explain how to proceed and the repercussions of your decision.

Please note that files of adults are destroyed after ten (10) years of inactivity.
I certify that I have received orientation regarding the services and programs offered by the CSCT.

Parent Signature: _____ **Date** _____

Name Printed: _____