

Notice of Collection of Personal Information

Personal information on this form is provided to your child care provider as required under subsection 35(2) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*. The information may be collected and used by the Ministry of Education in the course of confirming compliance with that subsection. The information may also be collected and used by the Medical Officer of Health pursuant to clause 72(6)(a) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014* in order to support the health and well-being of children. Questions about this collection should be directed to: Manager, Licensing and Compliance, Ministry of Education, 77 Wellesley Street West, Box 980, Toronto ON M7A 1N3, or by calling the Child Care Licensing Help Desk at 1-877-510-5333.

Section 1 – Child Information

Last Name		First Name	Date of Birth (yyyy/mm/dd)
Home Address			
Unit Number	Street Number	Street Name	
City/Town		Province	Postal Code
Child Care Centre / Home Child Care Agency			

Section 2 – Declaration of Regulated Health Professional

I, _____, (Name of Regulated Health Professional) (Last Name, First Name), certify that,

for medical reasons indicated below, the above named child should be exempted from the requirements of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*.

The specific reasons and length of exemptions are checked in the boxes below.

The time periods for temporary medical exemptions are indicated.

Disease	Immunity		Contraindication	Length of Exemption		
	Clinical diagnosis of prior disease	Laboratory confirmation of immunity or prior disease		Detrimental to health	Permanent	Temporary
Diphtheria			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Tetanus			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Pertussis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Poliomyelitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Meningococcal Disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Measles		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Mumps		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Rubella		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Haemophilus Influenza Type B (Hib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Varicella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/

*Clinical diagnosis of prior varicella or herpes zoster disease is acceptable for varicella immunity.

Use this space to define evidence of immunity.

Use this space for explanations of contraindications detrimental to health.

Section 3 – Signature

Name of Regulated Health Professional (Last Name, First Name)			Registration or Licence Number
Business Address			
Unit Number	Street Number	Street Name	
City/Town		Province	Postal Code
Signature of Regulated Health Professional			Date (yyyy/mm/dd)