Vancouver Coastal Health
Promoting wellness. Ensuring care.

IMMUNIZATION (VACCINATION) INFORMATION FOR CHILDCARE

Important: Please complete and return this form to your childcare facility. If you wish to complete this information online go to www.vch.ca/child-immunization-report

Dear Parent/ Guardian:

All childcare facilities in BC are required by law under the *Community Care and Assisted Living Act* to keep a record of each child's immunization history. These records are required to be made available to Vancouver Coastal Health Authority (VCH) medical health officers for public health programs. The information you provide on this form will be used to update your child's health record at VCH in order that: medical health officers may respond if a disease outbreak occurs in your childcare facility; public health staff can recommend immunizations which your child may be missing; and VCH is able to provide better care to your child as part of its public health programs.

PART A: CHILD AND FAMILY INFORMATION ****PLEASE PRINT CLEARLY****

Today's Date											
Childcare Facility Name											
Child's Name Surname		Given Name					Preferred Name				
SEX	**Birthdate** dd mm yyyy			**Birth Place** City		Province		Country			
Child's personal health number (BC Care Card)											
Home Address			**Postal Code**		**Home Phone**						

Health Care Provider's Name	**HCP Phone #**

	PARENT/GUARDIAN – FIRST CONTACT	**PARENT/GUARDIAN – SECOND CONTACT**
First Name		
Last Name		
Preferred Phone		
Text		
Email Address		

PART B: CHILD'S VACCINATION INFORMATION

1. Has your child had chickenpox disease at 12 months of age or older?

√ check the correct answer ☐ **Yes** ☐ **No** ☐ **Not Sure**

Children who have had chickenpox disease on or after 12 months of age are considered to have life-long immunity to chickenpox disease and do not require vaccination against chickenpox disease. Children who have not had chickenpox disease on or after 12 months of age (this includes children who had disease younger than 12 months of age) need 2 doses of chickenpox vaccine. Dose 1 should be received at 12 months of age and dose 2 should be received before entering kindergarten.

2. ATTACH A PHOTOCOPY **of your child's vaccination record to this form.**

For example: BC Child Health Passport OR immunization record. **Attach a copy of the original record** as it appears in English or any language. Ensure your child's name and date of birth are written on each page.

Please turn over for more information

THIS IS AN IMPORTANT NOTICE.
PLEASE HAVE SOMEONE TRANSLATE IT.

AMHARIC *(Ethiopia)*	ይህ ጠቃሚ ማስታወቅያ ነው:: እባክዎን ሌላ ሰው- ያስተርጉምልዎት::
BURMESE	ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက် ယောက်ကိုဘာသာပြန်ခိုင်းပါ။
CHINESE	這是一份重要通告，請找人爲您翻譯。
CROATIAN	OVO JE VAŽNO OBAVJEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
FRENCH	CECI EST UN AVIS IMPORTANT. PRIERE DE LE FAIRE TRADUIRE.
HINDI	यह एक बहुत ज़रुरी सूचना है। कृपया किसी से इसका अनुवाद करा लें।
ITALIAN	QUESTO È UN AVVISO IMPORTANTE. SIETE PREGATI DI FARVELO TRADURRE DA QUALCUNO.
KHMER *(Cambodia)*	នេះគឺជាសេចក្តីប្រកាសដ៏សំខាន់មួយ សូមអ្នករកអ្នកបកប្រែជូនអ្នក ។
KOREAN	중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
PERSIAN *(Iran)*	.این یک اطلاعیهٔ مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند
POLISH	TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
PUNJABI	ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲੱਥਾ ਕਰਵਾ ਲਵੋ।
SERBIAN	OVO JE VAŽNO OBAVEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
SOMALI	KANI WAA OGEYSIIS MUHIIM AH. FADLAN QOF HA KUU TURJUMO.
SPANISH	ÉSTE ES UN AVISO IMPORTANTE. POR FAVOR, BUSQUE A ALGUIEN QUE SE LO TRADUZCA.
TAGALOG *(Philippines)*	ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA MAUNAWAAN.
VIETNAMESE	ĐÂY LÀ THÔNG BÁO QUAN TRỌNG. HÃY NHỜ NGƯỜI DỊCH GIÚP.

Personal information on this form is collected, used and disclosed by VCH in accordance with the *Freedom of Information and Protection of Privacy Act*. Statistical information may be provided to the Ministry of Health for healthcare planning, program evaluation and quality improvement purposes. We may contact you in the future to ask whether you would like to participate in the evaluation of the school immunization program. VCH may need to email or text you information relating to your child's immunizations. Please be aware that your personal information may be stored outside of Canada by your email/messaging service provider and will be subject to the laws of that jurisdiction. If you have any questions about privacy, please contact VCH's Information Privacy Office at 604.875.5568 or privacy@vch.ca.

If you have any questions about immunizations or the collection and use of this information, or you would like to withdraw your consent to receive emails or texts, contact your local public health nurse at the community health centre near you – see list below.

For vaccination schedules and more information go to www.vch.ca or www.immunizebc.ca

Community Health Centres in Vancouver Coastal Health

Vancouver					
Evergreen 3425 Crowley Dr 604.872.2511	**Raven Song** 2450 Ontario St 604.709.6400	**Robert and Lily Lee Family** 1669 East Broadway 604.675.3980	**Pacific Spirit** 2110 West 43rd Ave 604.261.6366	**South** 6405 Knight St 604.321.6151	**Three Bridges** 1290 Hornby St 604.736.9844
Richmond	**North and West Vancouver**	**Squamish**	**Whistler**	**Pemberton**	
8100 Granville Ave 604.233.3150	604.983.6700	1140 Hunter Place 604.892.2293 or 1.877.892.2231	202 - 4380 Lorimer Rd 604.932.3202	1403 Portage Road 604.894.6939	
Coastal					
Gibsons	**Sechelt**	**Pender Harbour**	**Powell River**		
494 South Fletcher Rd 604.886.5600	5571 Inlet Ave 604.885.5164	5066 Francis Peninsula Rd 604.883.2764	3rd Floor, 5000 Joyce Ave 604.485.3310		
Central Coast					
Bella Bella	**Bella Coola**				
250.957.2308 ext 229	250.799.5722				

Anaphylaxis Emergency Action Plan

Child's Name: _____ Grade:____ Div: _____ Birthdate:_____

School Name: St. Patrick's Elementary School School Address: 2850 Quebec St. Vancouver B.C. V5T 3A9 School Phone: 604 879 4411

THIS PERSON HAS A POTENTIALLY LIFE THREATENING ALLERGY (ANAPHYLAXIS)

Allergy trigger(s):

☐ Food(s): _____

_____

_____

☐ Insect Stings: _____

☐ Other: _____

Medication:

☐ EpiPen Jr. (0.15mg) ☐ EpiPen Sr. (0.3mg)

Location:_____ Expiry:_____

ACT QUICKLY. DO NOT WAIT FOR SYMPTOMS TO GET WORSE OR NEW SYMPTOMS TO BEGIN

- **Give Epinephrine** at the first sign of an anaphylactic reaction.
- **Call 9-1-1**
- **Call Emergency Contact**

Epinephrine is the first line medication for the emergency management of anaphylaxis. **Antihistamines (e.g. Benedryl ™) or asthma medication should not be used to treat anaphylaxis.**

AN ANAPHYLACTIC REACTION MAY HAVE THE FOLLOWING SIGNS AND SYMPTOMS:

Face: Hives, itching, swelling (lips, face, tongue) flushed face or body

Airway: Difficulty breathing, swallowing or speaking, coughing , wheezing, change of voice, sneezing

Stomach: Stomach cramps, nausea, vomiting, diarrhea

Total body: Hives, itching, swelling, weakness, dizziness, loss of consciousness, anxiety, feeling of doom

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by a physician/NP. The plan will be shared with appropriate facility/school personnel to assist in responding in an Emergency. It is the parent/guardian's responsibility to advise the school about any changes to this plan.

_____ _____ _____ _____

Parent/Guardian Date Doctor/NP Signature Date

Anaphylaxis Emergency Plan is provided as a resource from Vancouver Coastal Health – April 2019
Adapted from the Anaphylaxis Emergency Plan on www.foodallergycanada.ca

Vancouver School Board

Asthma Emergency Action Plan

Child's Name: _____ Grade:____ Div: _____ Birthdate:_____

School Name: St. Patrick's Elementary School School Address: 2850 Quebec St. Vancouver B.C. V5T 3A9 School Phone: 604 879 4411

THIS PERSON HAS A SERIOUS (POTENTIALLY LIFE-THREATENING) ASTHMA ATTACKS

Asthma trigger(s):

- ☐ Food(s): _____
- ☐ Animal(s): _____
- ☐ Environment: _____
- ☐ Other: _____

Emergency Medication Information:

Medication Name: _____

Expiry Date:_____ Location:_____

☐ **Previous asthma attack requiring hospitalization**: Person is at greater risk

☐ **Previous Anaphylaxis:** If student has/is having difficulty breathing, give epinephrine auto-injector before asthma medication

ACT QUICKLY; GIVE EMERGENCY MEDICATION IMMEDIATELY

1. **Give Emergency Medication Instructions:**

_____

_____

_____

2. **If symptoms worsen or do not improve:**

   ➔ **CALL 9-1-1**

3. **Call emergency contact**

AN ASTHMA ATTACK MAY HAVE THE FOLLOWING SIGNS & SYMPTOMS

- Coughing
- Wheezing
- Tightness or pain in chest
- Unable to complete sentences due to shortness of breath
- Fast/shallow breathing
- Fear or anxiety
- Blue lips or nail beds
- Sweating

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named student in the event of an asthma attack. This protocol has been recommended by the student's Doctor/Nurse Practitioner. It is the parent/guardian's responsibility to advise the school about any changes to this plan.

_____ _____ _____ _____

Parent/Guardian Date Doctor/NP Signature Date

Asthma Emergency Plan is provided as a resource from Vancouver Coastal Health – April 2019
First aid information adapted from www.asthma.ca

Vancouver School Board