

SECTION 3 CHILD'S CASE FILE

3.1 Child's Case File

Standard 3.1(a)

A case file must be established for every child entering care under voluntary care, temporary care, or permanent care and custody. The child must be registered on the computerized case management system within one working day of the child's placement.

Procedures

The child's file, when in temporary or voluntary care, should include:

- reasons for coming into care and identified goals and objectives
- the child's medical history and health card number with expiry date
- court plan of care
- comprehensive plan of care
- initial assessment of needs
- medical and dental reports
- level of education and current school
- significant others in child's life
- religious, linguistic, racial, and cultural background
- access schedule (if drawn up)
- completed special allowance form (*see the appendix at the end of this section*); it is the social worker's responsibility to complete the application for special allowance when a child comes into care on either a temporary or permanent basis
- relationship with parents and/or family members

- copies of temporary care agreements
- copies of “Notices of Taking into Care” with review dates
- copies of psychological or educational assessments
- placement history
- copies of probation orders where applicable
- other significant information, e.g. child’s likes, dislikes, special skills, recreation, or social affiliations
- a copy of the child’s birth certificate or application for birth certificate

Case recording may be maintained on the children in care or protection file according to common practice.

When a child is in permanent care and custody, *in addition to the above*, the child’s file should include:

- the social and medical history (*see Section 5.22 of the Child Protection Services manual*)
- the order for permanent care and custody
- current medical and dental (*see the appendix at the end of this section*)
- copy of child’s social insurance number
- copy of all assessments involving child psychiatric, parental capacity assessments, etc.

Standard 3.1(b)

Where the child is in permanent care and custody, the child’s file must not be destroyed (*see Policy Statement 98*).

3.2 Life Books (Watch Me Grow)

Life books are an ongoing record of a child's life experiences subsequent to coming into permanent care and custody. The life book should be provided by the agency and maintained jointly by the caregiver and child, with supporting material provided by the agency. The life book provides a visible point of reference to a child's life and serves as a link of communication for the child, caregiver and caseworker. The life book is held in the possession of the child, by the caregiver, or by the social worker, depending on the developmental capability of the child.

Standard 3.2(a)

Every child in the permanent care and custody of a Children's Aid Society, Family and Children's Services, or district office of the Department must be provided with a life book.

Procedures

Life books will be provided to every child via caregivers. The child will be encouraged and assisted to maintain the life book by the caregiver and the social worker. The life book may include:

- photos and other memorabilia
- souvenirs and milestones
- report cards
- birth and baptismal certificates
- health card
- social insurance number (when accessed)
- certificate of achievements, e.g. awards, badges
- letters

The life book is the child's possession and will follow the child in the event of placement transfers and will be provided to the child upon discharge from care and custody. The life book *Watch Me Grow* is available through the head office of the Department. Where a child is being placed for adoption, care must be taken to make sure the life book contains non-identifying information only.

3.3 Case Management System

Standard 3.3(a)

An open placement must be maintained on each child in care on the case management system. The worker must change the placement within two working days of the child having moved.

The worker must complete all required BF's in the time specified. If it is not appropriate to complete these within the specified time, or the worker is unable to complete them, they must consult with their supervisor and document the reason.

**SECTION 3
APPENDIX**

1. Medical Form - Coming Into Care
2. Children's Special Allowances Application and Cancellation Form
3. Medical Form - Annual Update

Medical History—Coming Into Care

Name of Child		Sex M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth D ___ M ___ Y___		Place of Birth	
Address							
Date				Agency			
FAMILY HISTORY						PERINATAL DATA	
AGE OF NATURAL FATHER				AGE OF NATURAL MOTHER		ATTENDING PHYSICIAN	
CHECKLIST PLEASE CHECK APPROPRIATE BOX	NATURAL FATHER			NATURAL MOTHER		GESTATION	LENGTH OF LABOUR
	YES	NO		YES	NO	BIRTH WEIGHT	DISCHARGE WEIGHT
MENTAL ILLNESS						TYPE OF DELIVERY	
INTELLECTUAL IMPAIRMENT						BLOOD TYPE	APGAR
EPILEPSY						RESUSCITATION TYPE	ICTERUS (JAUNDICE)
BLEEDING DISEASE						SUGAR	HEMOGLOBIN
DRUG INGESTION						BLOOD GROUP	VDRL
VD						HEAD CIRCUMFERENCE	LENGTH
DIABETES						POST NATAL PROBLEMS	
ECZEMA						CONGENITAL DEFORMITIES	
ASTHMA							
HAY FEVER							
CONGENITAL HEART DISEASE							
OTHER - IF YES SPECIFY BELOW							
OTHER-NATURAL FATHER							
OTHER-NATURAL MOTHER							
FAMILY DOCTOR							

DEVELOPMENTAL MILESTONES				PSYCHOLOGICAL HEALTH	
	AGE		AGE	NOTE: ATTACH COPY OF REPORT(S)	
COOED AND SMILED		WALKED WITH SUPPORT		DATE OF TEST:	TYPE OF TEST:
ROLLED ABDOMEN TO BACK		WALKED ALONE		REASON	
GRASPED OBJECTS		WORDS		RESOURCE	
FIRST TEETH		SENTENCES		DATE OF TEST:	TYPE OF TEST:
SITS		TOILET TRAINED		REASON	
STANDS				RESOURCE	
IRREGULAR PATTERNS	EATING:				
SLEEPING					
BEHAVIOUR PATTERNS	ENURESIS:				
SOILING:			THUMB SUCKING:		
NAIL BITING:			MASTURBATION:		
OTHERS:					
	DATE	REASON	HOSPITAL	DOCTOR	
ALLERGIES					
PREVIOUS HOSPITALIZATION					
SERIOUS ILLNESSES					

IMMUNIZATION							
	DATE	PLACE	DOCTOR/NURSE		DATE	PLACE	DOCTOR/NURSE
DPTP				DTP			
DPTP				PT			
DPTP				OTHER			
MMR				OTHER			
DPTP				OTHER			
DPTP				OTHER			
DTP				OTHER			
MERUVAX (GIRLS)				OTHER			

FOR ADOLESCENTS				
CHECKLIST	YES	NO	HISTORY OF PREGNANCY	
IS CHILD SEXUALLY ACTIVE				
IS CHILD ON BIRTH CONTROL PILLS			HISTORY OF VD	
DOES CHILD ACCEPT RESPONSIBILITY			PREVIOUS ABORTIONS	
DOES CHILD NEED REMINDING			DRUG ABUSE	
IS CHILD RESPONSIBLE FOR HIS OWN MEDICAL AND DENTAL APPOINTMENTS			OTHER MEDICAL INFORMATION (ACNE, ETC)	

ONGOING MEDICAL HISTORY

INFECTIOUS DISEASES			
DISEASE	DATE	COMPLICATIONS	ATTENDING PHYSICIAN
WHOOPING COUGH			
DIPHTHERIA			
MUMPS			
MEASLES			
GERMAN MEASLES			
SCARLET FEVER			
TYPHOID-PARATYPHOID			
CHICKENPOX			
INFECTIOUS HEPATITIS			
OTHER DISEASES			

ORAL AND DENTAL HEALTH			
DENTIST	DATE	NO DECAYED TEETH	OBSERVATIONS & RECOMMENDATIONS

	DATE	REASON	HOSPITAL	DOCTOR
ALLERGIES				
PREVIOUS HOSPITALIZATION				
SERIOUS ILLNESS				

HISTORY OF MEDICAL EXAMINATIONS		
DATE	PHYSICIAN	RECOMMENDATIONS

PSYCHOLOGICAL HEALTH	
NOTE: ATTACH COPY OF REPORT(S)	
DATE OF TEST	TYPE OF TEST
REASON	RESOURCE
DATE OF TEST	TYPE OF TEST
REASON	RESOURCE

PROVINCE OF NOVA SCOTIA
DEPARTMENT OF COMMUNITY SERVICES

REPORT OF MEDICAL EXAMINER
Court and Annual Medical

NAME OF CHILD: _____ D.O.B. _____

NAME OF AGENCY: _____

Height _____ Head Circumference _____

Weight _____ Chest Circumference _____

General Condition _____

Development _____

Fontanelle _____

Head _____

Skin _____

Ears _____

Eyes _____

Teeth & Occlusion _____

Nose _____

Tonsils _____

Adenoids _____

Glands _____

Heart-Size _____

Position _____

Sounds _____

Femoral Pulses _____

Chest _____

Lungs _____

Abdomen _____

Spleen _____

Liver _____

Spine _____

Posture _____

Genitals _____ Circ. _____

Testis _____ Hernia _____

Extremities _____

Neurological _____

Endocrine _____

Blood Pressure _____

FINDINGS: _____

RECOMMENDATIONS: _____

DATE: _____ DR. _____

PEDIATRICIAN _____

ADDRESS _____

SECTION 3
REFERENCE MATERIAL

1. Child Protection Manual Case Recording Standards and Social History, Sections 7 and 5.22
2. Watch Me Grow - Life Book (available from Department of Community Services)
3. Case Management System Procedures Guide
4. Policy Statement #64

Children's Special Allowance Form

Follow the Children's Special Allowances link at: www.ccra.gc.ca/benefits/

SECTION 3 CHILD'S CASE FILE

Summary of Standards for child's Case File

- 3.1(a) A case file must be established for every child entering care under voluntary care, temporary care, or permanent care and custody. The child must be registered on the computerized case management system within one working day of the child's placement.**
- 3.1(b) Where the child is in permanent care and custody, the child's file must not be destroyed (*see Policy Statement 98*).**
- 3.2(a) Every child in the permanent care and custody of a Children's Aid Society, Family and Children's Services, or district office of the Department must be provided with a life book.**
- 3.3(a) An open placement must be maintained on each child in care on the case management system. The worker must change the placement within two working days of the child having moved.**

The worker must complete all required BF's in the time specified. If it is not appropriate to complete these within the specified time, or the worker is unable to complete them, they must consult with their supervisor and document the reason.