REGISTRATION FORM

CHILD

Full Name:______________________________________ Responds to:____________________________

Date of Birth: ________/ ______/ ______ YMD Start Date: ________/ ______/ ______YMD

Gender Identity: M _____ F _____O_____ Pronouns:______________________________

Address____ Postal code:____________________

PARENT(S) AND/OR GUARDIAN(S)

Name: ____ Cell:___________________________________

Address:_______________________________________ Email:_________________________________

Place of Work: __________________________________ Work Phone:____________________________

Name:____ Cell:__________________________________

Address:_______________________________________ Email:_________________________________

Place of Work:__________________________________ Work Phone:____________________________

EMERGENCY CONTACTS

*These people should be available during hours of care. Please provide a minimum of 2 contacts.

Name: ___________________________________Relationship to child: ____________________________

Home phone: __________________ Work phone: _________________Cell phone: _________________

Name: ___________________________________Relationship to child: ____________________________

Home phone: __________________ Work phone: _________________Cell phone: _________________

Name: ___________________________________Relationship to child: ____________________________

Home phone: __________________ Work phone: _________________Cell phone: _________________

Name: ___________________________________Relationship to child: ____________________________

Home phone: __________________ Work phone: _________________Cell phone: _________________

Is there anyone NOT permitted to pick up your child? YES ☐ NO ☐

Name:____

*please speak to your centre's manager if there are any concerns regarding pick up/custody etc.

Has your child previously attended daycare/preschool? YES ☐ NO ☐

Comments: ____

____

____

COMMENTS AND INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD

(Please feel free to add additional pages)

Toileting/Diapering (special words): ____

____

____

Rest Time (comfort item – toy/blanket, special words): _____________________________________

____

____

Eating/Mealtime (include food likes/dislikes): ____

____

____

Fears: ____

____

____

Please tell us anything else you think will help us provide an enriching experience for your child:

____

____

____

MEDICAL AND HEALTH INFORMATION

BC Personal Health Number (PHN): ____

Family Doctor/Clinic Name:_________________________________ **Phone**:__________________

Health professionals involved with your child (other than doctor and dentist):

Name:________________________________ Phone: __________________________________

Profession/Agency: ____

Immunization Records:

☐ I have attached a clear/legible copy or photo of my child's current immunization records

Does your child have any of the following health concerns?:

A medical condition? YES ☐ NO ☐

If yes, please provide further information:

____

____

____

Has your child had a seizure in the past year? YES ☐ NO ☐

If yes, please provide further information:

____

____

____

Asthma? YES ☐ NO ☐

If yes, please provide further information: ____

____

____

Allergies? YES ☐ NO ☐ If yes, is an Epi-Pen required? YES ☐ NO ☐

If yes, please provide further information: ____

____

____

Food sensitivities/intolerances? YES ☐ NO ☐

If yes, please provide further information: ____

____

____

Does your child require a special diet related to a medical condition? YES ☐ NO ☐

If yes, please provide further information: ____

____

____

List all prescription and 'over the counter' medications your child receives:

Medication: ______________________________ Times Given: ______________________________

Reason:____

Medication: ______________________________ Times Given: ______________________________

Reason:____

*You may be asked to complete additional forms if you answered yes to any of the above.

****I HEREBY CONSENT TO MY CHILD BEING TRANSPORTED BY AMBULANCE AND TREATED BY A MEDICAL PROFESSIONAL IN THE CASE OF AN EMERGENCY.****

Parent/Guardian:

Name: ____ Date: __________/_____/____YMD

Signature: ____

Staff Member:

Name: ____ Date: __________/_____/____YMD

Signature: ____

Registration Package Checklist

Please ensure all items are completed, sent digitally to Sophie, and a printed, paper copy of everything is brought to the centre on the first day:

- ☐ **Registration Form** completed and signed
- ☐ **Parent Agreement Contract** all pages initialed and last page signed
- ☐ A copy or photo of current **Immunization Records**
- ☐ Child's **PHN (BC personal health number)** filled out on registration form
- ☐ Name & number of child's **Doctor *or* Medical Clinic** filled out on registration form
- ☐ 2 current printed **Photos** of your child (required by VIHA licensing)