GILLYBIRD NATURE SCHOOLS LTD.
(Sitka and Sparrow Early Education)

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)/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 2 or more 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 the manager if there are any reasons we should be concerned with in regards to picking 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/HEALTH INFORMATION

BC Medical Services 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:

A medical condition/concern? 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, please provide further information: _____

_____

_____

Food sensitivities? 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. This health information may be made available to the staff of Vancouver Coastal Health.

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

Information Provided by:

Print Name: _____ Date: _____/_____/____YMD

Signature: _____

Received By Staff Member:

Print Name: _____ Date: _____/_____/____YMD

Signature: _____

Registration Package Checklist

Please ensure all items are complete and/or included in your registration package

- ☐ **Registration Form** completed and signed
- ☐ **Parent Agreement Contract** signed
- ☐ Copy/photo of current **Immunization Records** attached
- ☐ Child's **PHN (personal health number)** filled out on registration
- ☐ Name & number of child's **Doctor or Medical Clinic** filled out on registration
- ☐ 2 current **Photos** of your child attached for licensing requirements

  Photos do not need to be in colour and do not need to be on photo quality paper