

**Staff Use Only**

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_



# REGISTRATION FORM

Class Choice (Please circle one)      MWF AM      MWF PM      TTH AM

Full name of child: \_\_\_\_\_

Name child responds to (if different): \_\_\_\_\_

**Personal Information**

Child's date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Parent or Guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_ Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation and Employer Name: \_\_\_\_\_ Occupation and Employer Name: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Hours at this location: \_\_\_\_\_ Hours at this location: \_\_\_\_\_

**Emergency Health Information**

Care Card number: \_\_\_\_\_

Family doctor/clinic: \_\_\_\_\_ Family dentist/clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Child's Immunization Status**

Is your child up to date on immunizations?    YES    NO

Comments: \_\_\_\_\_

**Consent for Emergency Care**

I authorize the staff at the childcare centre to call a medical practitioner or ambulance in the case of an accident or illness of my child(ren), if the parent cannot immediately be reached

Signature of parent: \_\_\_\_\_ Date: \_\_\_\_\_

Manager of Facility: \_\_\_\_\_

**Person (s) Authorized to Pick Up Child (other than parent/guardian listed above)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there any person(s) NOT authorized to pick up your child:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there a custody agreement in effect:    YES    NO

If yes, please provide a copy of the custody order to the facility manager/licensee.

**Health Information (please attach a separate sheet, if necessary)**

Regular medication and reason: \_\_\_\_\_

Allergies and necessary treatment: \_\_\_\_\_

Injuries, illnesses, or operations your child has had (please include dates): \_\_\_\_\_

Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing etc.): \_\_\_\_\_

Please describe any concerns you may have regarding your child's development (behaviour, vision, hearing, speech, language, mobility etc.): \_\_\_\_\_

Other health care professionals involved in your child's life (occupational therapist, physical therapist etc.): \_\_\_\_\_

**Out-of-Home/Group Experience/Emotions and Transitions**

Has your child had any previous play group experience?    YES    NO

If yes, how did he/she adapt?: \_\_\_\_\_

How Does your child behave toward other children (seeks out friends, feels shy)? \_\_\_\_\_

What is/are your child's favourite toy(s)/activities? \_\_\_\_\_

How does your child react when left with unfamiliar people and/or in unfamiliar situations? \_\_\_\_\_

Does your child have any particular fears? Please describe: \_\_\_\_\_

What would help staff make your child's transition into this program easier? \_\_\_\_\_

**Family and General Household Information**

Other children living at home:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Other adults living at home:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please describe the guidance and discipline methods used at home: \_\_\_\_\_

Primary language spoken at home: \_\_\_\_\_ Other languages: \_\_\_\_\_

Name of English-speaking person (if needed): \_\_\_\_\_ Phone: \_\_\_\_\_

Are there any religious or ethnic observances in your family? \_\_\_\_\_

**Toileting**

Is your child toilet-trained?    YES    NO

Please indicate your child's frequency or patterns for toileting: \_\_\_\_\_

Describe assistance needed for toileting: \_\_\_\_\_

**Signature of Parent of Guardian Providing Information**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

*Note: this information may be reviewed by Fraser Health Authority Licensing staff as per provincial legislation.*

