



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: _____

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: _____

Staff Use Only

Start Date: _____

Withdrawal Date: _____

Reason for Withdrawal: _____

Staff person reviewing family's documents: _____

Signature: _____

Print Name: _____

Date: _____

Emergency Health Information

Care Card number: _____

Family doctor/clinic: _____

Family dentist/clinic: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Consent for Emergency Care

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

Signature of parent or guardian: _____ 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.

Child's Immunization Status

Is your child up to date on immunizations? YES NO

Please record dates (year/month/day) or attach a copy of immunizations:

	Diphtheria	Pertussis	Tetanus	Polio/MMR	(Measles/Mumps/ Rubella)	HIB
1						
2						
3						
4						
5						

Comments: _____

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

Regular medication and reasons: _____

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.): _____

Describe any specific care instructions regarding your child's health or development: _____

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: _____ Birthday/Age: _____

Name: _____ Relationship: _____ Birthday/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? _____

Would you be willing to share information with the class about your family's holiday observances? _____

Toileting

Is your child toilet-trained? YES NO Partially

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

Describe assistance needed for toileting: _____

What special word (if any) does your child use for: urination _____ bowel movements _____

Signature of Parent or Guardian Providing Information

Signature: _____ Print Name: _____ Date: _____

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per provincial legislation.