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REGISTRATION FORM FOR CHILD CARE

FACILITY NAME:	
FULL NAME OF CHILD:	USUAL NAME OF CHILD [IF DIFFERENT]:

PERSONAL INFORMATION

CHILD'S DATE OF BIRTH:	GENDER:	STARTING DATE:	
ADDRESS:		POSTAL CODE:	
		PHONE: ( )	
PARENT OR GUARDIAN:		PARENT OR GUARDIAN:	
ADDRESS [IF DIFFERENT FROM ABOVE]:		ADDRESS [IF DIFFERENT FROM ABOVE]:	
PHONE:		PHONE:	
WORK ADDRESS/ALTERNATE LOCATION:		WORK ADDRESS/ALTERNATE LOCATION:	
PHONE [INCLUDE LOCAL]:		PHONE [INCLUDE LOCAL]:	
CELLULAR/PAGER:		CELLULAR/PAGER:	
HOURS AT THIS LOCATION:		HOURS AT THIS LOCATION:	

EMERGENCY HEALTH INFORMATION

CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

CONSENT FOR EMERGENCY CARE

I authorize the staff at the child care 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/GUARDIAN:	DATE:
MANAGER OF FACILITY:	

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PERSON(S) AUTHORIZED TO PICK UP CHILD
(other than parent/guardian listed above)

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

PERSON(S) NOT AUTHORIZED TO PICK UP YOUR CHILD

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CUSTODY AGREEMENT: ☐ YES ☐ NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE

ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CHILD'S IMMUNIZATION STATUS
(Please record dates [year/month/day] or attach copy of immunization)

IS YOUR CHILD IMMUNIZED? ☐ YES ☐ NO

DIPHTHERIA	PERTUSSIS	TETANUS	POLIO	MMR (Measles/Mumps/Rubella)	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.		
4.	4.	4.	4.		
5.	5.	5.	5.		

COMMENTS:

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HEALTH INFORMATION

[Please attach a separate sheet, if necessary]

REGULAR MEDICATION[S] AND REASONS FOR [PLEASE LIST]:

ALLERGIES AND TREATMENT OF [PLEASE LIST]:

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S):

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

b) Please describe any concerns you may have regarding your child's development [i.e., behaviour, vision, hearing, speech, language, mobility, etc.]:

c) Describe any specific care instruction regarding a) and/or b):

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

GROUP EXPERIENCES

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? ☐ YES ☐ NO

IF YES, HOW DID HE/SHE ADAPT?

HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]:

EMOTIONAL

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 SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?

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FAMILY AND GENERAL HOUSEHOLD INFORMATION

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:	OTHER LANGUAGES:
NAME OF ENGLISH SPEAKING PERSON [IF NEEDED]:	PHONE:

ANY OTHER COMMENTS

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 legislation.

FACILITY USE ONLY

Staff person reviewing family's documents:

SIGNATURE:	PRINT NAME:	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR WITHDRAWAL:	

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ADMINISTRATION OF MEDICATION CONSENT FORM

CHILD'S NAME:		
PHYSICIAN'S NAME:		PHONE:
PHARMACY NAME:		PHONE:
MEDICATION:		PRESCRIPTION #:
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN ADMINISTERED TO THIS CHILD PREVIOUSLY? ☐ YES ☐ NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? ☐ YES ☐ NO	
TIMES TO BE GIVEN BY PARENT:		
TIMES TO BE GIVEN BY CARE PROVIDER:		
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?		

I hereby give permission and authorize _____ to administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.

Signature of Parent/Guardian	Date	Phone

CAREGIVER'S ADMINISTRATION RECORD:

DATE:	TIME GIVEN:	AMOUNT GIVEN:	ADMINISTERED BY: