

FACILITY NAME:

REGISTRATION FORM FOR CHILD CARE

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CARE CARD NUMBER: FAMILY DOCTOR/CLINIC NAME:			EAMILY DEA	ITIST/CLINIC NAME:			
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SIGNATURE OF PARENT/GUARDIAN:			DATE:				
MANAGER OF FACILITY:		ne a decigió de como porte de Mandre Media de Aspertador P	The second of th				
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SECTION 3(00SC Reg Fm 04-02-24)

HEALTH INFORMATION [Please attach a separate sheet, if necessary]
REGULAR MEDICATION[S] AND REASONS FOR [PLEASE LIST]:
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ALLERGIES AND TREATMENT OF [PLEASE LIST]:
STOAUUAAL RAHIN SAASSA
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:
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]:
NOTE: This informacine may be reviewed SANOITOMA Trailing My Licensing staff as per legislation
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 A	ND GENERAL HO	USEHOLD INFORM	MATION	
PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOP	PLE IN YOUR CHILD'S LIFE [E.G.,	SIBLINGS, GRANDPARENTS, ETC	c.]:	
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:		
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SIGNATURE OF F	PARENT OR GUAR	RDIAN PROVIDING	C BARTON SY	IATION
SIGNATURE:	PRINT NAME:		DATE:	
NOTE: This information may be	reviewed by Fraser	Health Authority Lic	ensing st	aff as per legislation.
	FACILITY U	ISE ONLY	VIII SA MORANA	
Staff person reviewing family's dod	cuments:		and the control of th	
SIGNATURE:	PRINT NAME:	1989-50-06-06-06-06-06-06-06-06-06-06-06-06-06	P ROBOTTSAF	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR V	VITHDRAWAL:	and the second s	



SECTION 3 (OOSC MedConsent 04-02-24)

ADMINISTRATION OF MEDICATION CONSENT FORM

CHILD'S NAME:						
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PHYSICIAN'S NAME:			PHONE:			
PHARMACY NAME:			PHONE:			
MEDICATION:	2		PRESCRIPTION #:			
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN AD	MINISTERED TO THIS CHI	LD PREVIOUSLY?	YES		NO
	IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM?					NO
TIMES TO BE GIVEN BY PARENT:						
TIMES TO BE GIVEN BY CARE PROVIDER:						
ANY POSSIBLE SIDE EFFECTS THAT YOU HA	VE BEEN MADE AWARE OF BY TH	E PHYSICIAN OR PHARMA	cy?			`
I hereby give permission and aut medication in the dosage as stat and/or drug manufacturer. I acc container, and I agree to submit	ed above. This dosage is ept the responsibility of su a new consent form if ther	pplying the current o	correct medication	on in its origi	inal tered.	
Signature of Parent	//Guardian 			Pilotie		
CAREGIVER'S ADMINISTRAT	TION RECORD:					
DATE:	TIME GIVEN:	AMOUNT GIVE	N: A	DMINISTER	ED BY	:
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