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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?

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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ADDITIONAL CHILD HISTORY

(OPTIONAL)

EATING AND NUTRITION

LIST YOUR CHILD'S FAVOURITE FOOD:

LIST ANY DISLIKED FOOD:

PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:

ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:

SLEEPING

NAP TIME:	HOW LONG TO SETTLE	TIME OF WAKING:
BEDTIME:	HOW LONG TO SETTLE	TIME OF WAKING:

IS YOUR CHILD A DEEP SLEEPER, OR DOES (S)HE AWAKEN EASILY?

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER [E.G., BLANKET OR TOY] TO BED? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED":

WHAT IS YOUR CHILD'S MOOD UPON WAKENING?

TOILETING

IS YOUR CHILD TOILET-TRAINED? ☐ YES ☐ NO ☐ PARTIALLY

PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:

DESCRIBE ASSISTANCE NEEDED FOR TOILETING:

WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR:

URINATION: _____ BOWEL MOVEMENTS _____

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: