R&D treehouse DAYCARE

Child Care Registration Form

FACILITY NAME	
FULL NAME OF CHILD	USUAL NAME OF CHILD *(if different)*

PERSONAL INFORMATION

CHILD'S DATE OF BIRTH	GENDER ☐ Male ☐ Female	STARTING DATE
ADDRESS		DAYCARE USE ONLY WITHDRAWAL DATE
POSTAL CODE	TELEPHONE ( )	

PARENT OR GUARDIAN	PARENT OR GUARDIAN
ADDRESS *(if different from above)*	ADDRESS *(if different from above)*
TELEPHONE ( )	TELEPHONE ( )
WORK ADDRESS / ALTERNATE LOCATION	WORK ADDRESS / ALTERNATE LOCATION
TELEPHONE *(Include Local / Extension)* ( )	TELEPHONE *(Include Local / Extension)* ( )
CELL PHONE / PAGER ( )	CELL PHONE / PAGER ( )
HOURS AT THIS LOCATION	HOURS AT THIS LOCATION

EMERGENCY HEALTH INFORMATION

CARE CARD NUMBER	
FAMILY DOCTOR / CLINIC NAME	DOCTOR / CLINIC TELEPHONE ( )

CONSENT FOR EMERGENCY CARE

I authorize the staff at the child care centre to call a medical practitioner or ambulance / transport child to emergency medical care, in the case of accident or illness of my child(ren), if the parent cannot immediately be reached. Yes ☐ No ☐

ALTERNATE PERSONS(S) AUTHORIZED TO PICK UP CHILD *(other than parent/guardian listed above, include emergency pickup)*

Check all that apply

Name	Relationship	Telephone	Authorized to Pickup	Authorized to Call in an Emergency
			☐	☐
			☐	☐

PERSONS(S) WHO ARE NOT PERMITTED ACCESS TO MY CHILD

Name	Relationship	Telephone

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CUSTODY OR OTHER LEGAL ORDERS

Yes ☐ No ☐	If yes, supply a copy of the order to the facility Manager / Licensee

CHILD'S IMMUNIZATION STATUS

Is your child up to date on immunizations? Yes ☐ No ☐ Not Immunized ☐

COMMENTS

HEALTH INFORMATION *(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)

1. Please describe any concern(s) / issues regarding your child's health (seizures, asthma, vision, hearing, etc).
2. Please describe any concerns you may have regarding your child's development (i.e. behaviour, vision, hearing, speech, language, mobility, etc.)
3. Describe any specific care instruction regarding 1) and/or 2) above.

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE *(e.g. occupational therapist / physical therapist)*

ANY OTHER INFORMATION I SHOULD KNOW

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 *(Facility has provided a copy of the following)*

1. Prepayment policy Yes ☐ No ☐
2. Behavioural Guidance Yes ☐ No ☐

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ADDITIONAL INFORMATION ABOUT YOUR CHILD (OPTIONAL)

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 DESCIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME.

PRIMARY LANGUAGE SPOKEN IN THE HOME	OTHER LANGUAGES
NAME OF ENGLISH SPEAKING PERSON (IFF NEEDED)	TELEPHONE

EATING AND NUTRITION

LIST YOUR CHILD'S FAVOURITE FOOD

LIST ANY DISLIKED FOOD.

PLEASE DESCIBE 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

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G. BLANKET OR TOY) TO BED?

Yes ☐ No ☐ IF YES, 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: _____