550 ROBERTSON STREET
WINNIPEG, MANITOBA R2X 2C4
T 204-586-7950 | F 204-589-7293

Child Care Registration Form

For Office Use Only

Date Contacted ______________________ Start Date Confirmed ___________________________

Notes: ____

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Program

Program (circle): Nursery Kindergarten 1& 2 Period Care Summer Only

Facility Start Date ____

General Information

Child First Name _______________________________ Last Name ____________________________________

Nick Name ________________________________

Weight __________ Height ___________

Sex (circle) M F Date of Birth _________________________

Special Needs and Subsidy Information

Subsidy Number ____________________________

Subsidy Start Date ____________________________ Expiry Date _____________________________________

Restrictions:

____

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Primary Contact (Parent/ Guardian)

First Name ______________________________ Last name ________________________________

Relationship _____________________________________

Primary Caregiver (Circle) YES NO

Address _________________________________City ____________ Prov _________ ZIP _________

Home Phone _________________________ Comments ____________________________________

Cell Phone ___________________________ Comments ____________________________________

Work Phone __________________________ Comments ___________________________________

E-mail ____

Occupation ____________________________ Employer Name _____________________________

Employer Address ________________________ City ____________ Prov __________ ZIP _________

Days & Hours Work ____

Circle all relevant:

Emergency Contact Lives With Pick up Authority Restraining Order

Contact (Parent/ Guardian)

First Name ______________________________ Last name ________________________________

Relationship _____________________________________

Primary Caregiver (Circle) YES NO

Address _________________________________City ____________ Prov _________ ZIP _________

Home Phone _________________________ Comments ____________________________________

Cell Phone ___________________________ Comments ____________________________________

Work Phone __________________________ Comments ___________________________________

E-mail ____

Occupation ____________________________ Employer Name _____________________________

Employer Address ________________________ City ____________ Prov __________ ZIP _________

Days & Hours Work ____

Circle all relevant:

Emergency Contact Lives With Pick up Authority Restraining Order

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Other Contact

First Name ______________________________ Last name ________________________________

Relationship _____________________________________

Primary Caregiver (Circle) YES NO

Address ________________________________City ___________ Prov _________ ZIP _________

Home Phone ________________________ Comments ____________________________________

Cell Phone __________________________ Comments ____________________________________

Work Phone _________________________ Comments ___________________________________

E-mail ____

Occupation ____________________________ Employer Name _____________________________

Employer Address _______________________ City ___________ Prov __________ ZIP _________

Days & Hours Work ____

Circle all relevant:

Emergency Contact Lives With Pick up Authority Restraining Order

Other Contact

First Name ______________________________ Last name ________________________________

Relationship _____________________________________

Primary Caregiver (Circle) YES NO

Address ________________________________City ___________ Prov _________ ZIP _________

Home Phone ________________________ Comments ____________________________________

Cell Phone __________________________ Comments ____________________________________

Work Phone _________________________ Comments ___________________________________

E-mail ____

Occupation ____________________________ Employer Name _____________________________

Employer Address _______________________ City ___________ Prov __________ ZIP _________

Days & Hours Work ____

Circle all relevant:

Emergency Contact Lives With Pick up Authority Restraining Order

Siblings

Sibling First Name ________________________________ Last Name _____________________________________

Program/ School ____

Sibling First Name ________________________________ Last Name _____________________________________

Program/ School ____

Sibling First Name ________________________________ Last Name _____________________________________

Program/ School ____

Health and Medical Information

MHSC No. ________________________ PHN No. __________________________ Health Plan No ______________

Allergies/ Medical conditions

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____

Diagnosis Agency ____________________________ Date of Diagnosis ____________________________________

Agency Involved (Circled) YES NO

Special Needs Diagnosis

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____

Tested for senses (Circle) YES NO

Required Treatment ____

____

Treatment Details ____

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Other Information:

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Growth and Development

Eating habits

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Food Dislikes

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Food Likes

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Languages Spoken

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Dominant Hand

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Nap information

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Dressing Help Info

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Toilet Help Info

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Favourite Activity

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Growth and Development (continued)

Playing Habits

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Playing Difficulties

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Friends

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Previous Care

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Guidance Method

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Other Info

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Family Physician

Title ____________________

First Name ___________________________________ Last name ____

Agency Name ____________________________ Position ________________ Field of Expertise________________

Address _____________________________________City ______________ Prov ___________ ZIP ___________

Home Phone _____________________________ Comments ____

Cell Phone _______________________________ Comments ____

Work Phone ______________________________ Comments ____

Alternate Phone ____________________________ Comments____

E-mail ____

Fax _________________________________ Employer Name __________________________________

Comments

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Other Consultant, Physician, Therapist

Title ____________________ Occupation _______________________

First Name ___________________________________ Last name ____

Agency Name ____________________________ Position ________________ Field of Expertise ________________

Address _____________________________________City ______________ Prov ___________ ZIP ___________

Home Phone _____________________________ Comments ____

Cell Phone _______________________________ Comments ____

Work Phone ______________________________ Comments ____

Alternate Phone ____________________________ Comments____

E-mail ____

Fax _________________________________ Employer Name __________________________________

Comments

____

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Schedule

Arrival Time ___________ Departure Time ____________ Days (circle) M T W Th F

Arrival Time ___________ Departure Time ____________ Days (circle) M T W Th F

Arrival Time ___________ Departure Time ____________ Days (circle) M T W Th F

Arrival Time ___________ Departure Time ____________ Days (circle) M T W Th F

Comments

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Child Care Pro Consent

Child Care Pro is a program used by Inspired by Wonder to store your child's information for our reference. We hereby request your consent to disclose the collected information to Vari Tech Systems Inc. for the purpose of managing the software Childcarepro on behalf of The Facility and in accordance with the Vari Tech Privacy Cod. I understand the Vari Tech systems Inc. will not disclose such personal information without my further consent unless required or permitted by the law.
For additional information about the Vari Tech Privacy Code please visit www.varitechsystems.com or contact the Vari Tech Privary Officer at 204-231-7068 or by email at admin@childcarepro.ca

Date ___________________________________ Signatures____

Emergency

If at any time, medical treatment is necessary due to a serious injury or sudden illness. I authorize the childcare facility to take whatever emergency measures deemed necessary for the protection of my child while in the care of the child care facility. I give permission for my child to receive medical attention deemed necessary by my child's doctor or other medical personnel. I understand that this may involve transportation to the hospital in a private vehicle or ambulance. I understand that the facility will make every attempt to contact me and that any expense incurred for such treatment, including ambulance fees, is my responsibility

Date ___________________________________ Signatures____

Field Trips

I give permission for my child to accompany the Facility on field trips. I understand that this includes excursions on foot, or on public transportation. (i.e. local parks/playgrounds). Advance notice will be given and individual permission requested.

Date ___________________________________ Signatures____

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Indirect Supervision

I give permission for indirect supervision.

Date ____________________________________ Signatures____

Learning Stories

I give the facility permission to take pictures of my child for Learning Story Documentation purposes. If there is a story completed or written on my child it may be sent home for family input and is to be sent back to the facility. I also understand that other children may be in the pictures and they will need to be kept in confidence. These Learning Stories will also be posted on the Facilities bulletin boards for all to view. These pictures may not be copied/scanned without the express consent of the Executive Director.

Date ____________________________________ Signatures____

Media

I give the facility permission, at the discretion of the Executive Director and/or Assistant Director, for photos or videos of my child to be used for the purpose of media (i.e. newspaper, television, SSCY collaborative services, social media, blogs, and/ or childcare website).

Date ____________________________________ Signatures____

Medicine

I will make every attempt to administer medication to my child at home. In the event that the medication needs to be administered during Facility hours, the following conditions will be respected:

- The medicine will be prescribed by a medical doctor
- Will be provided to a staff member in the original container with a legible prescription indicating the date, doctor's name, dosage, and instructions

I will sign a further, more detailed medicine consent form at that time.

Date ____________________________________ Signatures____

Parent Manual

I have received and read the parent manual. I understand and agree to abide by these policies.

Date ____________________________________ Signatures____

Photos/ Videos

I give permission for the Facility's staff to take pictures/ videos of my child for Facility use only. I agree to the centre sending pictures of children doing various activities pertaining to the grants that we may receive. These pictures may also be sent to photo stores (i.e. Walmart or Costco) for printing and making our photo books.

Date ____________________________________ Signatures____

Practicum

I give permission for my child to be observed by students in the fields of early childhood education or specialized services (including but not exclusive to occupational therapy, speech and language pathology, physiotherapy, and child development. This may include medical students.) if these observations are kept in confidence and used only as a means to fulfill their course requirements. These observations must be approved by the Facility. These observations may include written or photo documentation.

Date ____________________________________ Signatures____

Release of Information

I authorize the release of any information or records requested to the staff of the Facility. This information will generally be requested from schools or other professionals that are or have been involved with the child.

Date ____________________________________ Signatures____

Sunscreen/ Bug Spray

I hereby authorize the Facility to apply SUNSCREEN SPF 30+ and Bug Spray on my child during the season when children are at risk of the sun and bug bites. I am aware that I will be required to sign in June for a nominal fee to be applied to my account. If I wish my child to use special sunscreen/bugspray I will need to provide a bottle to the child care centre.

Date ____________________________________ Signatures____

Withdrawal

I am aware that I must provide the Facility with two (2) weeks written notice before withdrawing my child. If I fail to do this, I will be required to pay for two(2) weeks of fees and I will forfeit my deposit.

Date ____________________________________ Signatures____